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ABSTRACT

The report summarizes the findings from a 3-year evaluation of 11 child abuse and neglect demonstration service projects. The 11 projects are described in terms of their goals, service activities, organization and management styles, staffing patterns, resource allocations and service costs, types of clients served, methods of case management used, and community activities. Also discussed are the essential elements of a quality case management process, the factors associated with worker burnout, the factors associated with program efficiency, the relative effectiveness of alternative service strategies for abusive and neglectful parents, the cost-effectiveness of different services, and the effects of treatment for abused and neglected children. Recommendations regarding the elements of successful child abuse and neglect programs are also presented. An executive summary is included. (Author/DLS)

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RESEARCH REPORT
SERIES

Evaluation of Child Abuse and Neglect Demonstration Projects, 1974-1977, Vols. 1 and 2

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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Research Report Series

The *Research Report Series* is published by the National Center for Health Services Research (NCHSR) to provide significant research reports in their entirety. Research Reports are developed by the principle investigators who conducted the research, and are directed to selected users of health services research as part of a continuing NCHSR effort to expedite the dissemination of new knowledge resulting from its project support.

ABSTRACTS

Evaluation of Child Abuse and Neglect Demonstration Projects, 1974-1977

Volume 1: *Executive Summary*: This report summarizes the findings from a three year evaluation of eleven child abuse and neglect demonstration service projects. Contents include a description of the methodology, project profiles, comparative descriptions of projects, project management aspects, as well as description of other components of the study related to the quality of case management process. Conclusion and recommendations are also outlined. (PB 278 438)

Volume 2: *Child Abuse and Neglect Treatment Programs: Final Report and Summary of Findings*: This report summarizes the findings from a three-year evaluation of eleven child abuse and neglect demonstration service projects. Contents include: a description of the eleven demonstration projects in terms of their goals, service activities, organization and management styles, staffing patterns, resource allocations and service costs, types of clients served, methods of case management used and community activities; the factors associated with worker burnout; the essential elements of a quality case management process; the factors associated with program efficiency; the relative effectiveness of alternative service strategies for abusive and neglectful parents and the cost-effectiveness of different services; the effects of treatment for abused and neglected children. Recommendations regarding the elements of successful child abuse and neglect projects are also presented. (PB 278 439)

Volume 3: *Adult Client Impact*: In addition to describing the kinds of clients served, the kinds of services provided and the impacts of services on clients at eleven demonstration child abuse/neglect projects, this report presents an analysis of the effectiveness of alternative service strategies for abusive and neglectful parents. Several different kinds of impact measures are used, including reincidence while in treatment and reduced propensity for future maltreatment by the time services are terminated. The analyses include: the relationship between different client characteristics and impact; the relationship between different mixes of services received and impact; and the combined relationships between client characteristics, services received and impact. Analyses are presented for individual projects and for the whole demonstration program. The report includes a detailed discussion of the methodology. (PB 278 440)

Volume 4: *A Comparative Description of the Eleven Federally Funded Child Abuse and Neglect Demonstration Projects*: This report is a descriptive analysis of eleven demonstration child abuse and neglect services projects, spread across the country and in Puerto Rico. It includes discussion of the projects' goals, the major activities they pursue, how resources were used, their organizational base and management structure, staffing patterns, services provided to clients and to the rest of the community, the types of clients served and how cases were managed. The report stresses the similarities and differences across projects and the kinds of problems they encountered in implementing their problems. (PB 278 441)

Volume 5: *Community Systems Impact*: This report presents an analysis framework for studying the impacts of eleven demonstration child abuse and neglect projects on their local child abuse and neglect service systems. In the context of this framework, the impact of individual projects on their community systems and a comparative analysis of impact are discussed. Central to the analysis are factors associated with improvement in the following areas: community coordination mechanisms; interdisciplinary input at all treatment stages; a centralized and responsible reporting system; availability of a comprehensive set of services; the quality of case management throughout the system and the level of community education and public awareness. (PB 278 442)

Volume 6: *Quality of the Case Management Process*: This report describes the development of a methodology for determining the quality of the case management process in child abuse and neglect service programs as well as the application of this method to nine of eleven demonstration child abuse and neglect service projects. Included in the report are: a detailed discussion of the methodology; an assessment of the feasibility of collecting reliable data on this subject in the child abuse field; a description of the case management process at the demonstration projects; and an analysis of the factors associated with high quality case management. Suggested minimal standards of case management for the field are presented as well. The method used is adapted from the medical care quality assessment field. (PB 278 443)

Volume 7: *Cost Report*: This report provides an analysis of the utilization of resources (both dollars and personnel) in eleven demonstration child abuse and neglect service projects. The allocation of individual project and over-all program resources to different service and treatment activities are presented. The unit costs of different treatment services and the consequent costs of alternative service program models are discussed. The report includes analysis of service volume and the factors associated with cost efficiency in child abuse programs. Also included is a detailed discussion of the cost analysis methodology. (PB 278 444)

Volume 8: *Methodology for Evaluating Child Abuse and Neglect Service Programs*: This report presents a detailed discussion of the methodologies used in evaluating eleven child abuse and neglect demonstration service projects. These methods, which should be adaptable to non-demonstration child abuse and neglect projects as well, include: measuring project goal attainment; monitoring project resource allocation and service costs; determining the quality of the project's case management process; analyzing project organization and management and their relationships with worker job satisfaction and burnout; assessing the effectiveness of alternative service strategies for abusive and neglectful parents; monitoring the progress of abused and neglected children while in treatment; and assessing the impact of a project on its local child abuse and neglect system. In addition to describing the evaluation process, problems encountered and the methods used, the report contains all relevant data collection instruments and instruction manuals. (PB 278 445)

Volume 9: *Project Management and Worker Burnout*: This report describes the organization and management of eleven demonstration child abuse and neglect projects and analyzes the relationships between salient organization, management and worker characteristic variables with the presence and degree of worker burnout in these projects. Worker burnout is defined and a list of indicators of burnout is presented. In addition to determining which of a number of factors appear to be most highly associated with burnout, the report presents a series of recommendations to local child abuse and neglect projects on ways to avoid worker burnout. The findings are equally applicable to other kinds of social service agencies. A detailed discussion of the methodology used is also provided. (PB 278 446)

Volume 10: *Guide for Planning and Implementing Child Abuse and Neglect Programs*: This guide describes the process of planning and implementing child abuse and neglect service programs. It begins with a description of the planning process and the essential elements of a well-functioning community-wide child abuse and neglect service system. The steps involved in conducting a community needs assessment are presented as well as the kinds of problems typically encountered in setting up a new program. Methods for identifying project goals and examples of realistic goals are presented. Alternative program designs are described as are alternative treatment strategies a program may wish to provide. Methods for monitoring case management practices, client progress and project resource allocation are talked about and sample case record and program record instruments are supplied. The guide concludes with a discussion of ways to ensure cooperative working relationships with other community agencies and among program staff and ways to avoid worker burnout, as well as summary comments about how to enhance the likelihood of establishing an effective program. (PB 278 447)

Volume 11: *Child Impact*: The kinds of children served and the progress made by these children during treatment at three of eleven demonstration child abuse and neglect service projects are discussed. Information on the problems abused and neglected children had at the time they entered treatment and the progress made on those problems during the treatment process forms the basis for the analysis. Categories of problems areas include: physical development; socialization skills; and interaction with peers, adults and family members. The report includes a discussion of the difficulties in studying abused and neglected children with the use of standardized tests and the methodology used in this study. (PB 278 448)

Volume 12: *Historical Case Studies: Eleven Child Abuse and Neglect Projects, 1974-1977*: A detailed description of each of eleven demonstration child abuse and neglect service projects is provided in this report. Contents include discussion of: the community context; the project's history; organization and staffing patterns; project components; implementation and operation problems; project goals and how well they were accomplished during three years of federal funding; project management and worker satisfaction and burnout; clients served and the impact of services on those clients; impact of the project on the local community; resource allocation and service volume and costs; and plans for continuation after federal funding. (PB 278 449)

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RESEARCH REPORT
SERIES

Evaluation of Child Abuse and Neglect Demonstration Projects, 1974-1977

Vols. 1 and 2: Child Abuse and Neglect Treatment Programs: Final Report and Summary of Findings

Berkeley Planning Associates
August 1978

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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This *NCHSR Research Report* describes work by the Berkeley Planning Associates, Berkeley, California 94704. The work was performed for NCHSR under contracts HRA 106-74-120 and HRA 230-76-0075.

The Berkeley Planning Associates evaluation team included Anne H. Cohn, Project Director; Frederick C. Collignon, Principal Investigator; Katherine Armstrong; Linda Barrett; Beverly DeGraaf; Todd Everett; Donna Gara; Mary Kay Miller; Susan Shea; Ronald Starr; Helen Davis; and Shirley Langlois.

This volume and the other 11 in "Evaluation of Child Abuse and Neglect Demonstration Projects, 1974-1977" are available from the National Technical Information Service, Springfield, VA 22161 (tel.: 703/557-4650) (both in paper and in microfiche), order numbers PB 278 438 through PB 278 449. The order number for the complete set is PB 278 437.

Abstracts of currently available volumes, with their NTIS order numbers, begin on the inside front cover.

A synopsis and conversion of the findings and conclusions of the evaluation project is in preparation and is expected to be issued as an NCHSR publication (*Child Abuse and Neglect: Research and Policy Making*, DHEW Pub. No. (PHS) 78-3218).

Additional copies of this report may be obtained on request from the NCHSR Office of Scientific and Technical Information, 3700 East-West Hwy., room 7-44, Hyattsville, MD 20782 (tel.: 301/436-8970). Other current NCHSR publications are announced at the back of this publication.

FOREWORD

This report is one of a series presenting the findings of a three-year evaluation of eleven demonstration projects in child abuse and neglect services. The evaluation was conducted by the National Center for Health Services Research (NCHSR) under contract with Berkeley Planning Associates (BPA) in cooperation with the National Center on Child Abuse and Neglect (NCCAN), Office of Child Development. The report is a result of unusual interagency cooperation in funding demonstrations and evaluating them, setting an example for Federal coordination and cooperation. The demonstration projects were funded by two Federal agencies – the Office of Child Development (now the Administration for Children, Youth and Families), and the Social Rehabilitation Service (now the Administration for Public Service; both are now part of the Office of Human Development Services, HEW). – and the evaluation was undertaken by a third agency, NCHSR, using special set-aside evaluation funds.

The evaluation involved both descriptive analysis of the eleven demonstrations, along with cost effectiveness analysis of the services provided by the demonstrations. It should be pointed out that the evaluation was concerned with projects selected for the unique approaches they intended to demonstrate and not because they were representative of child abuse and neglect projects across the country. The methods used were largely developed for the evaluation study, and since this was the first such study of its kind, it is expected to stand as an important state-of-the-knowledge development in child abuse and neglect program evaluation.

It is our belief that, because of the important work performed under this contract with BPA, follow-up evaluations will gain greater insight in designing and implementing future evaluations. The tentative and suggestive findings of this study are expected to aid policy makers in deciding the type and kinds of services to be supported and funded. It should be stressed that because of the nature and design of the evaluation effort and the fact that no control groups were studied, the findings cannot and should not be generalized for all child abuse and neglect programs, nor can they be viewed as conclusive. They are, however, suggestive of directions child abuse and neglect treatment programs might take.

NCHSR acknowledges the imaginative, conscientious and diligent efforts of BPA staff, along with the cooperation and assistance of the Office of Child Development.

Gerald Rosenthal, Ph.D.
Director
August 1978

PREFACE

In May of 1974, the Office of Child Development and Social and Rehabilitation Services of the Department of Health, Education, and Welfare jointly funded eleven three-year child abuse and neglect service projects to develop strategies for treating abusive and neglectful parents and their children and for coordination of community-wide child abuse and neglect systems. In order to document the content of the different service interventions tested and to determine their relative effectiveness and cost-effectiveness, the Division of Health Services Evaluation of the National Center for Health Services Research, Health Resources Administration of the Department of Health, Education, and Welfare awarded a contract to Berkeley Planning Associates to conduct a three-year evaluation of the projects. This report is one of a series presenting the findings from that evaluation effort.

This evaluation effort was the first such national study in the child abuse and neglect field. As such, the work must be regarded as exploratory and suggestive, not conclusive. Many aspects of the design were pioneered for this study. Healthy debate exists about whether or not the methods used were the most appropriate. The evaluation focused on a demonstration program of eleven projects selected prior to the funding of the evaluation. The projects were established because of the range of treatment approaches they proposed to demonstrate, not because they were representative of child abuse programs in general. The evaluation was limited to these eleven projects; no control groups were utilized. It was felt that the ethics of providing, denying or randomly assigning services was not an issue for the evaluation to be burdened with. All findings must be interpreted with these factors in mind.

Given the number of different federal agencies and local projects involved in the evaluation, coordination and cooperation was critical. We wish to thank the many people who helped us: the federal personnel responsible for the demonstration projects, the project directors, the staff members of the projects, representatives from various agencies in the projects' communities. Ron Starr, Shirley Langlois, Helen Davis and Don Perlgut are all to be commended for their excellence in processing the data collected. And in particular we wish to thank our own project officers from the National Center for Health Services Research--Arne Anderson, Feather Hair Davis and Gerald Sparer--for their support and input, and we wish to acknowledge that they very much helped to ensure that this was a cooperative venture.

Given the magnitude of the study effort, and the number and length of final reports, typographical and other such errors are inevitable. Berkeley Planning Associates and the National Center for Health Services Research would appreciate notification of such errors, if detected.

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EXECUTIVE SUMMARY

EVALUATION OF THE JOINT OCD/SRS NATIONAL DEMONSTRATION PROGRAM IN CHILD ABUSE AND NEGLECT

1974-1977

Introduction

In May of 1974, prior to expenditure of funds appropriated to the Child Abuse and Neglect Prevention and Treatment Act, Public Law 93-247, the Office of Child Development and Social and Rehabilitation Services of DHEW jointly funded eleven three-year child abuse and neglect service projects in order to develop and test alternative strategies for treating abusive and neglectful parents and their children and alternative models for coordination of community-wide child abuse and neglect systems. The projects, spread throughout the country and in Puerto Rico, differed by size, the types of agencies in which they were housed, the kinds of staff they employed, and the variety of services they offered. Health Resources Administration awarded a contract to Berkeley Planning Associates to conduct a three-year evaluation of the projects. The overall purpose of this evaluation was to provide guidance to the federal government and local communities on how to develop community-wide programs to deal with problems of child abuse and neglect in a systematic and coordinated fashion. The study, which combined both formative (or descriptive) and summative (or outcome/impact-related) evaluation concerns, documented the content of the different service interventions tested by the projects and determined the relative effectiveness and cost-effectiveness of these strategies. Specific questions, addressed with quantitative and qualitative data gathered through a variety of collecting techniques, notably quarterly five-day site visits, special topic site visits and information systems maintained by the projects for the evaluators, include:

- What are the problems inherent in and the possibilities for establishing and operating child abuse and neglect programs?
- What were the goals of each of the projects and how successful were they in accomplishing them?
- What are the costs of different child abuse and neglect services and the costs of different mixes of services, particularly in relation to effectiveness?
- What are the elements and standards for quality case management and what are their relationships with client outcome?
- How do project management processes and organizational structures influence project performance and, most importantly, worker burnout?

- What are the essential elements of a well-functioning child abuse and neglect system and what kinds of project activities are most effective in influencing the development of these essential elements?

- What kinds of problems do abused and neglected children possess and how amenable are such problems to resolution through treatment?

- And, finally, what are the effectiveness and cost-effectiveness of alternative service strategies for different types of abusers and neglectors?

This document summarizes the findings of the evaluation with respect to the above questions.

I. Methodology

The study was divided into discrete study components, each with a different methodological approach:

General Process Component. In order to determine the problems inherent in establishing and operating child abuse and neglect programs and to identify the range of management and service strategies for such programs, all aspects of the projects' operations were carefully monitored, primarily through the quarterly five-day site visits by BPA staff. During these structured site visits, interviews, group discussions, record reviews and observation techniques were used. All of the problems and possibilities encountered both in setting up and running different project components were documented. Historical Case Studies of each of the projects, detailing all their activities over the three-year demonstration period, were prepared. Analysis of common experiences across projects resulted in the development of a Handbook for Planning and Implementing Child Abuse and Neglect Programs.

Project Goals Component. For purposes of assessing the extent to which projects accomplished their own unique set of goals, during site visits in the first year of the evaluation, using Andre Delbecq's Nominal Group Process Technique, BPA assisted each project in the clarification of its own specific and measurable goals and objectives. Project staff, administration and advisory board members participated in this reiterative process. At the end of the first year, with project input, attainment measures for each of the goals and objectives were identified, and at the end of the second and third years, BPA staff, using interviews and record reviews, assessed the extent to which projects had accomplished that which they had set out to do.

Cost Analysis Component. To determine the costs of different services, approximately one month out of every four project staff monitored their time and resource expenditures in relation to a set of discrete project activities or services on cost accounting forms developed by BPA. Donated as well as actual resources were accounted for, as were the number of units of service provided in each of the service categories. Calculations were then made for the percentage distribution of all resources to discrete activities and the unit costs of different services provided by each project in the sample months and on average for the operational phase of the project. The value of donated resources was added to unit costs to determine the total value of services provided. And, once adjustments were made for regional wage and price differences, comparisons were made across projects to determine both the average costs and the most efficient methods of delivering services.

Quality of the Case Management Process Component. In the interest of identifying standards for quality case management process and understanding the relationship between case management and client outcome, BPA consulted with a number of child abuse and medical care audit specialists to identify both the elements of and methods for assessing the quality of case management. The methodology, once pretested at four sites and refined, consisted of visits by teams of child abuse/neglect experts to the projects during their second and third years to review a random sample of case records from each of the treatment workers in a project and interview the workers about those cases reviewed. Descriptive and multivariate analyses allowed for the identification of the most salient aspects of case management and norms of case management across the projects which can serve as minimal standards for the field. By combining these data with that collected through the adult client component, the relationships between case management and client outcome were identified.

Project Management and Worker Burnout Component. In order to determine how project management processes and organizational structures influence project performance and in particular worker burnout, visits were made to each of the projects in the third year to elicit information about management processes, job design and job satisfaction, through interviews and/or questionnaires with project management and staff (including those who had left the project). A combination of both quantitative and qualitative data analysis was then carried out to define organizational and management aspects of the projects, to establish the prevalence of worker burnout among staff, and to determine the relationships between these factors.

Community Systems Component. In order to determine the extent to which the projects had an influence on their local communities in establishing a well-functioning, community-wide child abuse and neglect system, data on the functioning of the eleven communities' child abuse and neglect systems were collected. A series of interviews with personnel from the key agencies (protective services, hospitals, law enforcement, schools, courts and foster care agencies) in each community were conducted to determine the status of the community system before implementation of the project, including the services available, coordination mechanisms, knowledge of state reporting laws, resources committed to child abuse and neglect, the ways in which agencies functioned with respect to individual cases, and how agencies worked together around specific cases or general system problems. These people were re-interviewed at yearly intervals to collect information about the changes which had occurred or were occurring in each community. Each project also maintained data for this evaluation on the educational and coordination activities which project staff undertook to improve their community systems, and the nature and results of these activities. In addition to the above data, supplemental information about changes in each community system was obtained during each site visit from project personnel, project advisory board members, and knowledgeable individuals in the community. Analyses of the information gathered included comparing the essential elements of a well-functioning community-wide system with changes seen in project communities.

Children's Component. Even though very few of the projects directly provided treatment services to the abused or neglected child, because of the paucity of information on the kinds of problems abused and neglected children possess and the benefits of various treatment services for these children, clinicians at the three projects working with children maintained problem-oriented records, developed by BPA, on the children served from the time of intake through termination. The analysis, which included data gathered through the use of select standardized tests, identified the range of problems children possessed and the degree to which these problems appear to be resolvable during treatment.

Adult Client Component. Central to the entire study was the effort to determine the effectiveness and cost-effectiveness of alternative service strategies for different types of abusers and neglectors. Clinicians at the projects maintained complete records, on forms developed by BPA, on 1724 adult clients receiving treatment during 1975 and 1976, from the time of intake through termination. Data included: basic demographics, information on the nature and severity of the maltreatment, the amount and type of services received by the client, and outcome information including improvements in parents' functioning and reincidence of abuse or neglect. These data were first analyzed by project and for the whole demonstration program to determine the relationships between client characteristics, services received and outcome. Then, data from other parts of the study, including case management and program management information, were included to determine the extent to which these other variables help explain outcome. Finally, data on service costs were used to determine the cost-effectiveness of alternative strategies.

Limitations. The evaluation was concerned with projects selected because of the unique or different approaches they intended to demonstrate, not because they were representative of child abuse and neglect programs across the country. The methods used were largely developed for this study, given it was the first of its kind in the field. No control groups were studied. Thus, the findings cannot be generalized to all child abuse and neglect programs, nor can they be viewed as conclusive. They are, however, suggestive of directions child abuse and neglect treatment programs might take.

II. Project Profiles

As a group, the projects demonstrated a variety of strategies for community-wide responses to the problems of abuse and neglect. The projects each provided a variety of treatment services for abusive and neglectful parents; they each used mixes of professionals and paraprofessionals in the provision of these services; they each utilized many different coordinative and educational strategies for working with their communities. While not an exhaustive set of alternatives, the rich variety within a project and across projects has provided the field with an opportunity to systematically study the relative merits of different methods for attacking the child abuse and neglect problem.

While the projects embraced similar goals, each project was also demonstrating one or two specific and unique strategies for working with abuse and neglect, as described below:

The Family Center: Adams County, Colorado. The Family Center, a protective services-based project housed in a separate dwelling, is noted for its demonstration of how to conduct intensive, thorough multidisciplinary intake and preliminary treatment of cases, which were then referred to the central Child Protective Services staff for ongoing treatment. In addition, the Center created a treatment program for children, including a crisis nursery and play therapy.

Pro-Child: Arlington, Virginia. Pro-Child demonstrated methods for enhancing the capacity and effectiveness of a county protective services agency by expanding the number of social workers on the staff and adding certain ancillary workers such as a homemaker. A team of consultants, notably including a psychiatrist and a lawyer, were hired by the project to serve on a multidisciplinary review team, as well as to provide consultation to individual workers.

The Child Protection Center: Baton Rouge, Louisiana. The Child Protection Center, a protective services-based agency, tested out a strategy for redefining protective services as a multidisciplinary concern by housing the project on hospital grounds and establishing closer formal linkages with the hospital including the half-time services of a pediatrician and immediate access of all Center cases to the medical facilities.

The Child Abuse and Neglect Demonstration Unit: Bayamon, Puerto Rico. In a region where graduate level workers are rarely employed by protective services, this project demonstrated the benefits of establishing an ongoing treatment program, under the auspices of protective services, staffed by highly trained social workers with the back-up of professional consultants to provide intensive services to the most difficult abuse and neglect cases.

The Arkansas Child Abuse and Neglect Program: Little Rock, Arkansas. In Arkansas, the state social services agency contracted to SCAN, Inc., a private organization, to provide services to all identified abuse cases in select counties. SCAN, in turn, demonstrated methods by which a resource poor state, like Arkansas, could expand its protective services capability by using lay therapists, supervised by SCAN staff, to provide services to those abuse cases.

The Family Care Center: Los Angeles, California. The concept behind the Family Care Center, a hospital-based program, was a demonstration of a residential therapeutic program for abused and neglected children with intensive day-time services for their parents.

The Child Development Center: Neah Bay, Washington. This Center, housed within the Tribal Council on the Makah Indian Reservation, demonstrated a strategy for developing a community-wide culturally-based preventive program, working with all those on the reservation with parenting or family-related problems.

The Family Resource Center: St. Louis, Missouri. A free-standing agency with hospital affiliations, the Family Resource Center implemented a family-oriented treatment model which included therapeutic and support services to parents and children under the same roof. The services to children, in particular, were carefully tailored to match the specific needs of different aged children.

Parent and Child Effective Relations Project (PACER): St. Petersburg, Florida. Housed within the Pinellas County Juvenile Welfare Board, PACER sought to develop community services for abuse and neglect using a community organization model. PACER acted as a catalyst in the development of needed community services, such as parent education classes, which others could then adopt.

The Panel for Family Living: Tacoma, Washington. The Panel, a volunteer-based private organization, demonstrated the ability of a broadly-based multidisciplinary, and largely volunteer program, to become the central provider of those training, education and coordinative activities needed in Pierce County.

The Union County Protective Services Demonstration Project: Union County, New Jersey. This project demonstrated methods to expand the resources available to protective services clients by contracting for a wide variety of purchased services from other public and, notably, private service agencies in the county.

III. Comparative Description of Projects

Project Goals. The range or scope of project goals were similar, embracing concerns for educating the general public and professionals about child abuse, helping to bring about a more coordinated community system, and the testing out of some particular set of treatment strategies for abusive and neglectful families, although the steps or means established for accomplishing these goals varied. For all projects, goals shifted during the first year as community needs and staff capabilities became more clearly defined; the shifts in goals resulted in more clear and realistic objectives. The amount of time required to clarify and stabilize goals may have been reduced with the assistance of the evaluators. In general, projects were more successful in accomplishing their community-oriented than their treatment-oriented goals.

Project Structures. The projects represented different ways in which child abuse and neglect service programs might be organized and the kinds of activities they might pursue. Six of the projects (Adams County, Arlington, Baton Rouge, Bayamon, Arkansas and Union County) were housed in protective service agencies; two in hospitals (Los Angeles and St. Louis); two in private agencies (St. Petersburg and Tacoma); and one in a tribal council (Neah Bay). Two of the projects served as the community-wide coordinating body for child abuse and neglect (Tacoma and St. Petersburg). While none of the projects focused on primary preventive services, all performed certain educational and coordinative activities that contribute to primary prevention. Two projects (Neah Bay and St. Petersburg) pursued secondary preventive services; the remainder focused on direct treatment services. Of those performing direct treatment, four (Adams County, Arlington, Los Angeles and St. Louis) provided services to both parents and children (of those, only three, all but Arlington, provided therapeutic services to children) and the remainder served only parents. Four of the projects used primarily professional workers (Arlington, Baton Rouge, Bayamon and Union County); two (Arkansas and Tacoma) represent primarily a lay or volunteer staff model; the remainder had mixed staff.

Implementation. The projects implemented the programs they intended to demonstrate with varying difficulty and in varying amounts of time (in as few as four months in Arlington and Baton Rouge, and over 18 months in Neah Bay and Los Angeles). Critical determinants of this appeared to include: relationship of proposal writers with project administration; relationship of host agency to other community agencies; complexity of the proposed demonstration; and the degree to which the organizational framework for the project was in place when funding occurred.

Organization and Management Styles. While the projects themselves, given their demonstration status, were all relatively small, informal and unstable compared to most existing state and local social service agencies, one sees diversity among them on many organizational and management characteristics. Notable differences between projects include budget, staff and caseload sizes, the diversity of activities pursued, and the numbers of different disciplines or agencies actively involved with the project, the degree of formalization of job design, job flexibility, rule observation, and the degree to which general organizational or specific job-related decisions were centralized.

Staffing Patterns and Staff Characteristics. It is difficult to describe and compare staffing patterns and staff characteristics given the relatively small staff sizes, the high turnover rates and the constant flux in number and types of staff positions and program participants. Core staff sizes ranged from three to 25; the average number of individuals (including consultants and volunteers) participating in a project ranged from five to 134. The majority of staff members across all projects were female. Some projects had a high proportion of professionally trained staff or staff with several years of experience in the field; others had very few. All projects used volunteers in a wide range of treatment, educational and support capacities. While volunteers were important additions to the projects, they did not come "free" but cost a project in terms of management, supervision and consultation time. Six projects (Arlington, Bayamon, Baton Rouge, Neah Bay, Tacoma and Union County) experienced a turnover in directors. Projects that hired new directors from existing staff (all but Baton Rouge and Tacoma) appeared to have many fewer problems of continuity and "down time" than projects that hired new directors from the outside. Because of the multiple demands on projects like these, treatment projects (including all but Bayamon and Neah Bay) benefitted from sorting out the functions of directing a project from those of supervising the treatment activities into two separate staff positions (a project director and a direct services coordinator). Projects with active advisory boards (Arlington, Arkansas, St. Petersburg, Tacoma and Union County) had an easier time solving problems as they arose, or anticipating them in advance, than did projects without such boards.

Project Activites and Resources. While the amount of time spent on different project activities and the magnitude or volume of the activities varied across projects, projects did pursue many of the same things.

The demonstration projects as a group, staffed by approximately 450 people (including volunteers), spent $2.21 million annually, which was matched by over $330,000 a year in donated resources. With an average of 800 cases in treatment per month over 2200 new cases were opened by the projects each year. Countless others received minimal, supportive services from the projects. Direct treatment services focused on the abusive or neglectful parent, with individual counseling being the most widely offered service, supplemented by crisis intervention, multidisciplinary team review and lay therapy services. Fewer than 175 children received direct treatment services from the projects each year. However, over 50,000 professional and lay people annually received direct education or training in matters pertaining to child abuse and neglect.

On an average, 25% of the projects budgets were used for community-oriented activities, 65% for direct treatment services and 10% for research. The allocation of project resources to different activities was quite stable during the period when projects were operational.

The unit costs of direct treatment services varied considerably with lay and group services being about the least expensive (with an across project average of $7.25 per lay therapy counseling contact; $9.50 per person for a parent education class; $10.50 per person for a group therapy session). Individual counseling cost about twice as much as lay therapy counseling ($14.75 per contact). Multidisciplinary team reviews cost the projects an average $54.75 per review; however, when the volunteered time of consultants is ascribed a dollar value, the cost per review rises to $125.50. Comparisons across projects revealed that projects with larger service volumes provided group services at lower unit costs; unit costs of individual-client services were not a reflection of service volume.

Characteristics of Families Served. A study of the characteristics of the families served by the projects suggests that despite projects' specific intake of admissions criteria, which influenced to some extent the kinds of cases served, projects still ended up serving a variety of cases. Projects found that many cases referred were accepted for treatment because they could not get services elsewhere, rather than because the parents had committed the kinds of abuse or neglect the project wanted to serve. Projects also realized that all cases are complex, changing over time such that a potential case becomes an actual case or an abusive parent develops neglectful patterns. This suggests that while projects may have decided to focus on a particular kind of case, caseloads could not be exclusive, and service offerings had to be flexible enough to meet the range of needs clients had.

The projects did serve a heterogenous group of clients, who, as a group, differ from cases routinely handled by public protective services departments in that a somewhat greater proportion are physical abuse (as opposed to neglect) cases; and they tend to have somewhat larger families, higher educational levels and suffer from financial and health problems as well as social isolation. While household conflict is not a problem among this study population as it is with protective services cases in general, the study cases are more likely to have been abused as children.

The most frequently offered service to clients was that of one to one counseling (including individual counseling and individual therapy). This service was most often complemented with crisis intervention, multidisciplinary team reviews, lay therapy, couples and family counseling, child care, transportation and welfare assistance. All other services were offered to 15% or fewer of the clients. Clients, on average, received three different types of services, were in treatment six to seven months, and had contact with service providers about once a week. Approximately 24% of the clients received a service package which included lay services (lay therapy counseling and/or Parents Anonymous) along with other services. Only 13% received a group treatment package (including group therapy or parent education classes as well as other services); and over half (57%) received a social work model package (individual treatment and other services but no lay or group services).

Service receipt varied somewhat depending upon the type of maltreatment; cases designated as serious (in terms of the severity of the assault on the child) were more likely to receive multidisciplinary team case review couples/family counseling and crisis intervention. Some client characteristics appear to have been relevant in decisions to provide clients with certain mixes or models of service.

Approximately 30% of the cases in the study population were reported to have severly reabused or neglected their children while they were in treatment. By the end of treatment, 42% of the clients who at intake appeared to be likely repeaters were reported to have reduced propensity for future abuse or neglect. A somewhat smaller percent were said to have improved somewhat in aspects of daily functioning indicated to be a problem at intake.

Handling of Cases. More than one-half of the cases were contacted within three days of the initial report. Before coming to a decision on the plan of treatment for a client, usually at least one more meeting with the client in addition to the first contact was made; treatment services then would typically begin within two weeks of first contact with the client. Despite the interest and attention in the field to multidisciplinary review of cases, the typical case in the sample was not reviewed by a multidisciplinary review team at any time in the process. Use of outside consultants on the management of the case also was not the norm. On the other hand, whereas case conferences or staffings usually were not used on the case at intake or termination, there was a likelihood that such a conference was held sometime during the treatment phase of the case. The manager of the case was usually the person who also carried out the intake, and further, the typical case had only one case manager. Other than the primary case manager there was likely to be at least one other person in the project working with the client, and, at the same time, the client usually also received services from an outside agency. Evidence of communication and coordination with the source of the report and with outside treatment providers (if the client was receiving such services) was also the norm, but active client participation in treatment planning and reassessment was not the usual practice. On average, throughout the history of the case, the case manager would meet with the client about once or twice a month. After a case was terminated, usually a follow-up contact was made either with the client or with another service provider still working with the client. Many of these practices can serve as minimal case handling standards for others in the field.

Community Contexts and Constraints. The communities in which the projects were located varied by size and key demographic characteristics; these community characteristics did not seem to affect the implementation or short term operation of the projects as much as the nature of the local child abuse and neglect delivery system.

Attempts to better coordinate local child abuse and neglect systems took to form of organizing community-wide multi-agency coordinating groups and developing formal coordinative agreements with various agencies around the handling of specific case-management functions. Although there was no relationship between the project's sponsorship (e.g., public agency or independent) and their success in developing coordinating bodies, there was a relationship between sponsorship and a given project's ability to stimulate formal coordinating agreements between agencies on a system-wide basis. Thus, those projects that were protective service agency-affiliated developed more coordinative agreements between themselves and other agencies than independent projects.

The development of multi-disciplinary teams, either community-wide or agency-specific (project or hospital teams) was the primary method of securing interdisciplinary input for case review and management, although several projects also hired staff or consultants of various disciplines to extend the primary social work orientation of most community systems.

Centralized reporting systems and 24-hour coverage for the receipt of reports appear to have been solved satisfactorily in each of the demonstration communities except one. State legislation was clearly the major input to development of a centralized reporting system, and most often to the development of 24-hour coverage as well.

Each of the demonstration projects resulted in increased amounts and types of services available in their communities for dealing with child abuse and neglect cases, but the projects were generally unable to effect the provision of additional services by other community agencies. Many of the projects added relatively innovative services such as self-help programs, counseling hotlines, or educational services; since these services were generally available to only project clients, however, unless the projects were affiliated with the local protective services agency, the services were provided to only a small proportion of the community's cases. Preventive services were generally inadequate in the communites and only a few projects addressed these problems in any way. There was little proliferation of services for abused and neglected children. The utilization of community resources besides the demonstration projects and protective service agencies was generally poor. And, except for communities where the demonstration projects were housed in, or affiliated with, the local protective service agency, little change in the quality of case management, system-wide, was observed.

All of the projects provided extensive education and training to both professional and community residents. This education and training, although mostly focused on professionals, reached a wide audience; between 3,000 and 28,000 people in each community were educated during the course of the demonstration.

In summary, although the projects did have success in correcting many of the deficiencies in the community systems, especially problems of coordination, expansion of services under the projects' auspices, and professional education, several problems remain in the project communities at the end of the demonstration period. Coordination among both public and private agencies is inadequate; interdisciplinary input, while provided for in some cases, is not afforded the majority of the communities' cases; existing community resources have not been fully utilized in the provision of services; child neglect and high risk cases are provided minimal services; preventive services and therapeutic services for children are inadequate; and the case management function, particularly with respect to adherence to appropriate termination procedures and the provision of follow-up, is generally less than optimally carried out.

IV. Program Management and the Work Environment: The Causes of Worker Burnout

In order to gain insights into those organizational, management and personnel factors that contribute toward a positive work environment and thus reduce the likelihood of worker burnout (workers becoming separated or withdrawn from the original meaning and purpose of their work, estranged from their clients, their co-workers, the agency they work for such that they cannot and do not perform well on the job), each of the eleven projects' management processes and the attitudes of all workers at the projects were studied in detail. Data were collected from 162 workers. After identifying worker characteristics, management descriptors and organizational structure descriptors at each of the projects, these sets of factors were studied independently in terms of their relationship with the degree to which workers were burnt out. The most salient worker, management and organizational variables were then considered in combination to determine which had the stronger effects on burnout.

With structured, supportive program leadership standing out as the most influential management factor with respect to worker burnout, all of the following variables were found to have substantial or important effects: supportiveness; strength of program leadership; amount and clarity of communication; whether or not a worker had supervisory responsibility; degree of innovation allowed; age of worker; caseload size; the experience and sex of workers; and the degree to which rule observation was formalized.

It appears that burnout is not merely a function of a workers' own personal characteristics but also of the work environment. In order to avoid or diminish burnout among workers, and thus to enhance the longevity of worker and project performance, it would seem that a program needs to have quality leadership, clear communication, shared supervisory responsibility or supportive supervision, and smaller caseload sizes. A program should permit innovation as well as lack of adherence to certain formalized rules when it is in the best interest of clients. And programs should work carefully with younger, less experienced workers to help them avoid burnout.

V. The Essential Elements of a Quality Case Management Process

In order to determine the feasibility of measuring the quality with which cases were handled and to begin to identify the essential elements of quality case management, a representative sample of case managers' cases at nine of the demonstration projects were studied with respect to the case handling practices used, characteristics of the case manager, characteristics of the case and overall expert ratings of quality. Data on over 350 cases were analyzed with the following results:

Feasibility of Measuring Quality. It was found that reviewers can reliably collect factual information about case handling and that while acknowledged experts in the field generally rate quality in the same way as persons knowledgeable about child abuse but not "clinical experts," judgments about quality cannot be finely distinguished. At this point in the development of the field, judgments can only reliably be made between "good practice" and "less good practice."

Factors Associated with High Quality Intakes. The factors most highly associated with expert-judged quality intakes include: use of a multidisciplinary review team; minimal time (within one day, preferably) between the report and first client contact, use of outside consultation, and use of the same case manager for conducting the intake and managing ongoing treatment. The more education and experience the case manager has, the more likely that the intake will be of higher quality. Responsiveness of clients is also a factor in quality intakes.

Factors Associated with High Overall Quality Case Management. The factors most highly associated with expert-judged overall quality are: minimal time between the report and first client contact; use of outside consultants; frequent contact (ideally once a week) with client during the history of the case; a longer time in process (over six months); a difference in ethnicity between the client and the manager. Clients perceived as responsive to treatment are more likely to receive quality case management. Factors with less significant but substantively interesting effects on quality include: contacting the reporting source for background information on the case; using multidisciplinary review teams and following up on clients after termination.

The Relationship between Elements of Case Management and Clinician-Reported Client Outcome. Of all the case management processes studied, the two with a direct relationship to clinician-reported client outcome are: smaller caseload size (under 20) and longer time in process (over six months). While quality case management greatly facilitates service delivery, and thus presumably client outcome, quality case management per se in this study was not shown to have a direct relationship with outcome.

VI. Treating Abusive and Neglectful Parents

In order to assess the relative effects of alternative service strategies for different types of abusers and neglectors, data on 1724 parents who received treatment from the projects were studied both by project and for the whole demonstration. The finding include:

Reincidence While in Treatment. Most client characteristics are not highly associated with reincidence. The type of abuse or neglect that brought the case into treatment in the first place and the seriousness of that maltreatment, however, are useful predictors in whether or not there will be reincidence. The services a client receives may be a function of whether or not reincidence in treatment has occured or may help explain why there is or is not reincidence. Keeping this in mind, specialized counseling is the service most highly associated with severe reincidence Seriousness of the assault that brought a case into treatment has a much stronger relationship with reincidence than these or any other services, or service models.

Improvement in Select Areas of Daily Functioning. Clients who both physically abuse and neglect their children, emotional maltreaters and clients with severe household situations (including a history of abuse and neglect) are less likely to improve on the functioning indicators used in this study. Other client descriptors have either very small or no relationship to whether or not such improvement is reported. Clients who are in treatment for at least six months, and clients who received lay services (lay therapy counseling or Parents Anonymous) are the clients most likely to show improved functioning (in those areas cited as a problem at intake) by the end of treatment. While no one discrete service stands out as having a strong effect on this outcome when others are controlled for, the lay service model (receipt of lay therapy and/or Parents Anonymous along with other services) does have the strongest effect of the service models studied. The lay model also has the strongest effect on improvement in each of the select areas of functioning, followed by the group model (receipt of group therapy or parent education classes along with other services).

Reduced Propensity for Future Abuse or Neglect. While potential and physical abusers are reported to be somewhat more likely to have reduced propensity for future abuse and neglect than other types of maltreators, there do not appear to be any client descriptors that have a strong effect on this outcome. Clients receiving lay services (Parents Anonymous and lay therapy) were reported to be those more likely to have improved by the end of treatment than clients receiving other services. Length of time in treatment appeared to have a strong effect on outcome; frequency of contact had a small but substantively interesting effect. The only client descriptors which helped to explain outcome when considered along with service provision were the absence of substance abuse as a problem and the absense of severe reincidence during treatment. When cases are studied by type of maltreatment, the lay model continues to appear as having a stronger effect than other services for all groups except physical abusers, for whom the group service model has a slightly stronger effect.

Outcome Findings and Implications. Given that about 30% of the clients served were reported with severe reincidence while in treatment, the initial intervention strategies of the projects are called into question, suggesting that projects were not successfully protecting families' children. Also only 42% of the projects' clients who were reported at the beginning of treatment to be likely repeators, many of whom did severely reabuse or neglect during treatment, were found to have reduced propensity for future abuse or neglect by the end of treatment. Comparisons with findings from other studies to determine the validity of this finding are not possible, given the paucity of other evaluation studies in the field and lack of comparability between those completed to date. These findings do suggest that (a) more effective, early intervention strategies for protecting the child must be identified, and (b) irrespective of the success of early intervention, most child abuse and neglect programs currently can probably not expect to have much more than a 40-50% success rate.

Treatment Outcome Findings and Cost Implications. It was learned in this study that relative to any other discrete services or combinations of services, the receipt of lay services -- lay therapy counseling and Parents Anonymous -- combined with other services is more likely to result in positive treatment outcome. Group services (group therapy, parent education classes) as supplements to a treatment package also have a notable effect particularly for the physical abuser. Providing treatment for more than six months also appears to contribute toward treatment success.

These services which proved more effective also tend to be those which are the least expensive. For example, providing lay therapy counseling to a client for one year is estimated to cost $377 as contrasted with $546 for group therapy and $767 for individual counseling. The annual cost for a client in a program emphasizing lay services is $1380 as contrasted with $1691 in a program emphasizing individual counseling. The cost per successful outcome in a lay-oriented program is $2590 per client year, the most cost-effective treatment program. Comparable costs per successful outcome in a program emphasizing non-lay individual counseling is $4662 and $4081 in a program emphasizing group services. The group model is more effective and less costly than the social work model. In addition, it is more cost-effective to keep a client in treatment over six months.

VII. Treating Abused and Neglected Children

In order to determine the characteristics and types of developmental, emotional and psycho-social problems which abused and neglected children have, and the effects of providing therapeutic interventions to ameliorate these problems, the children receiving direct services at three demonstration projects were followed from intake through termination. Data on 70 children, and 44 of their parents, were analyzed with the following results.

Problems of Abused and Neglected Children. Children who entered the projects for treatment displayed a wide variety of problems; there was not one area in which all children were deficient, nor were there specific types of problems or behaviors which clustered together. The greatest number of children had problems in the following area: (1) physical problems -- hyperactivity, erratic eating patterns, excessive crying behavior, and the presence of tics and twitches; (2) socialization problems -- poor interaction with peers and adults, over-reation to frustration and very short attention spans; (3) family interaction problems -- inappropriate perception of child's needs and response to these needs, child's differences from parent's expectations and child's provocative behavior; (4) cognitive/language/motor skill problems -- the majority of the children tested below one standard deviation under the mean on several standardized tests, placing them in the clinical "dull normal" range.

Progress While in Treatment. Many children made some progress on their problems while in treatment; the problems of 50% of the children were reported to be completely ameliorated in areas of malnutrition, delayed height and head circumference, eating patterns, ability to gain and receive affection, hypermonitoring, and ability to protect themselves, apathetic behavior, general interaction with peers and the parent's use of harsh discipline on the child. At the time of termination, most children had significantly higher scores on the standardized tests administered (meaning cognitive, language and motor skill) although they were still at the low end of the "normal" range. Many children's problems, however, remained unchanged, and a small proportion were reported to have regressed during treatment.

Factors Associated with Progress in Treatment. The seriousness of the case at intake, the presence of abuse or neglect reincidence while in treatment, and the length of treatment were not shown to be good predictors of how a child will progress in treatment. Children appeared to have scattered success in overcoming their problems in much the same way that they exhibited a wide variety of problems, and intensity of problems, at the time they entered treatment.

VIII. Conclusions and Recommendations

In conclusion, it would appear that child abuse and neglect services are maximized if:

- they are closely linked with or housed within public, protective services agencies;
- the program participates cooperatively with law enforcement, local schools, hospitals and private social service agencies in the community in the identification and treatment of abuse and neglect as well as the education and training of professionals and the general public;
- the program has strong, supportive leadership, a variety of disciplines on the staff, decentralized decision making, clearly specified rules but allowance for flexibility of the rules as clients' needs dictate;
- the program stresses certain aspects of case management including prompt, planful handling of cases, frequent contact with cases, small caseload sizes, coordination with other service providers and use of multidisciplinary review teams and consultant input for the more complex or serious cases;
- the program utilizes more highly trained, experienced workers as case managers, but stresses the use of lay services (lay therapy) and self-help services (Parents Anonymous) as part of its treatment offerings, as well as 24-hour availability;
- careful supervision is available to lay workers, particularly during the first few months they are working with a case.
- therapeutic treatment services are provided to the abused or neglected child

Even the more successful child abuse and neglect service programs should not expect to be completely effective with their clients. To successfully treat half of one's clients, so that they need not become protective service cases in the future, appears to be a norm for the field.

INTRODUCTION

HISTORY OF THE DEMONSTRATION EFFORT[1]

During the fall of 1974, prior to the passage of the Child Abuse Prevention and Treatment Act, Public Law 93-247, the secretary's office of the federal Department of Health, Education and Welfare (DHEW) decided to allocate four million dollars to child abuse and neglect research and demonstration projects. A substantial portion of that allotment, approximately three million dollars, was to be spent jointly by the Office of Child Development's (OCD) Children's Bureau, and Social and Rehabilitation Services (SRS) on a set of demonstration treatment programs. On May 1, 1974, after review of over 100 applications, OCD and SRS jointly selected and funded eleven three-year projects.[2] The projects, spread throughout the country, differ by size, the types of agencies in which they are housed, the kinds of staff they employ, and the variety of services they offer their clients and their local communities. However, as a group the projects embrace the federal goals for this demonstration effort, which include:

(1) to develop and test alternative treatment approaches for treating abusive and neglectful parents and their children;

(2) to develop and test alternative ways for coordination of community-wide systems providing preventive, detection and treatment services to deal with child abuse and neglect;

(3) to document the content of the different service interventions tested and to determine their relative effectiveness and cost-effectiveness.

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[1] For a detailed listing of major events that occurred during the demonstration period, see Appendix A, "Milestones in the Demonstration Effort."

[2] The projects include: The Family Center: Adams County, Colorado; Pro-Child: Arlington, Virginia; The Child Protection Center: Baton Rouge, Louisiana; The Child Abuse and Neglect Demonstration Unit: Bayamon, Puerto Rico; The Arkansas Child Abuse and Neglect Program (SCAN): Little Rock, Arkansas; The Family Care Center: Los Angeles, California; The Child Development Center: Neah Bay, Washington; The Family Resource Center: St. Louis, Missouri; The Parent and Child Effective Relations Project (PACER): St. Petersburg, Florida; The Panel for Family Living: Tacoma, Washington; and the Union County Protective Services Demonstration Project: Union County, New Jersey.

OVERVIEW OF THE DEMONSTRATION EVALUATION

In order to accomplish the third goal, as part of DHEW's strategy to make this demonstration program an interagency effort, the Division of Health Services Evaluation, National Center for Health Services Research of the Health Resources Administration (HRA) awarded an evaluation contract to Berkeley Planning Associates (BPA) in June 1974, to monitor the demonstration projects over their three years of federal funding, documenting what they did and how effective it was.

The overall purpose of the three-year evaluation was to provide guidance to the federal government and local communities on how to develop community-wide programs to deal with the problems of child abuse and neglect in a systematic and coordinated fashion by documenting the content of the different service interventions tested by the demonstration projects and determining their relative effectiveness and cost-effectiveness. More specifically, the goals of the evaluation included:

(1) to determine the problems inherent in and possibilities for establishing and operating child abuse and neglect programs;

(2) to identify individual project goals and assess the extent to which they were accomplished;

(3) to determine the costs of different child abuse and neglect services and more specifically the costs of different mixes of services relative to their effectiveness;

(4) to determine the elements of a quality case management process and their relationship to client outcome;

(5) to determine how project management processes and organizational structures influence project performance and most notably worker burnout;

(6) to determine the extent to which the projects had an influence in their local communities in establishing a well-functioning community-wide child abuse and neglect system;

(7) to determine what kinds of problems abused and neglected children possess and how amenable such problems are to resolution through the provision of treatment services;

(8) to determine the effectiveness of alternative services for different types of abusers and neglectors.

Thus, the evaluation combined concerns both formative (descriptions of what was going on in the projects) and summative (assessments of the impact or outcome of different activities). The formative or descriptive information was useful not only in interpreting or explaining the summative data, but also as a tool in providing general technical assistance to the projects to enhance their progress.

The data were gathered through quarterly five-day site visits to the projects, other special site visits, and information systems maintained by the projects for the evaluator. Specific study components and the methodology for each are described briefly below.

General Descriptive Component

In order to determine the problems inherent in establishing and operating child abuse and neglect programs and to identify the range of management and service approaches for such programs, all aspects of the projects' operations were carefully monitored, primarily through the quarterly five-day site visits by BPA staff. During these structured site visits, interviews, group discussions, record reviews and observation techniques were used. All of the problems encountered both in setting up and running different project components were documented. Historical Case Studies of each of the projects, detailing all of their activities over the three-year demonstration period, were prepared. Analysis of common experiences across projects resulted in the development of a Handbook for Planning and Implementing Child Abuse and Neglect Programs.

Project Goals Component

For purposes of assessing the extent to which projects accomplished their own unique set of goals, during site visits in the first year of the evaluation, using Andre Delbecq's Nominal Group Process Technique, BPA assisted each project in the clarification of its own specific and measurable goals and objectives. Project staff, administration and advisory board members participated in this reiterative process. At the end of the first year, with project input, attainment measures for each of the goals and objectives were identified, and at the end of the second and third years, BPA staff, using interviews and record reviews, assessed the extent to which projects had accomplished that which they had set out to do.

Cost Analysis Component

To determine the costs of different services, approximately one month out of every four, project staff monitored their time and resource expenditures in relation to a set of discrete project activities or services on cost accounting forms developed by BPA. Donated as well as actual resources were accounted for, as were the number of units of service provided in each of the service categories. Calculations were then made for the percentage distribution of all resources to discrete activities and the unit costs of different services provided by each project in the sample months and on average for the operational phase of the project. The value of donated resources was added to unit costs to determine the total value of services provided. And, once adjustments were made for regional wage and price differences, comparisons were made across projects to determine both the average costs and the most efficient methods of delivering services.

Quality Case Management Process Component

In the interest of identifying standards for a quality case management process and understanding the relationship between case management and client outcome, BPA consulted with a number of child abuse and medical care audit specialists to identify both the elements of and methods for assessing the quality of case management. The methodology, once pretested at four sites and refined, consisted of visits by teams of child abuse/neglect experts to the projects during their second and third years to review a random sample of case records from each of the treatment workers in a project and interview the workers about those cases reviewed. Descriptive and multivariate analyses allowed for the identification of the most salient aspects of case management and norms of case management across the projects which can serve as minimal standards for the field. By combining these data with that collected through the adult client component, the relationships between case management and client outcome were identified.

Project Management and Worker Burnout Component

In order to determine how project management processes and organizational structures influence project performance and in particular worker burnout, visits were made to each of the projects in the third year to elicit information about management processes, job design and job satisfaction, through interviews and/or questionnaires with project management and staff (including those who had left the project). A combination of both quantitative and qualitative data analysis was then carried out to define organizational and management aspects of the projects, to establish the prevalence and nature of worker burnout among staff and to determine the relationships between these factors.

Community Systems Component

In order to determine the extent to which the projects had an influence on their local communities in establishing a well-functioning, community-wide child abuse and neglect system, data on the functioning of the eleven communities' child abuse and neglect systems were collected.

A series of interviews with personnel from the key agencies (protective services, hospitals, law enforcement, schools, courts and foster care agencies) in each community were conducted to determine the status of the community system before implementation of the project, including the services available, coordination mechanisms, knowledge of state reporting laws, resources committed to child abuse and neglect, the ways in which agencies functioned with respect to individual cases, and how agencies worked together around specific cases or general system problems. Then people were reinterviewed at yearly intervals to collect information about the changes which had occurred or were occurring in each community. Each project also maintained data for this evaluation on the educational and coordination activities which project staff undertook to improve their community systems, and the nature and results of these activities. In addition to the above data, supplemental information about changes in each community system was obtained during each site visit from project personnel, Project Advisory Board members, and knowledgeable individuals in the community. Analyses of the information gathered included comparing the essential elements of a well-functioning community-wide system with changes seen in the projects' communities.

Children's Component

Even though very few of the projects directly provided treatment services to the abused or neglected child, because of the paucity of information on the kinds of problems abused and neglected children possess and the benefits of various treatment services for these children, clinicians at the three projects working with children maintained problem-oriented records, developed by BPA, on the children served from the time of intake through termination. The analysis, which included data gathered through the use of select standardized tests, identified the range of problems children possessed and the degree to which these problems appear to be resolvable during treatment.

Adult Client Component

Central to the entire study was the effort to determine the effectiveness and cost-effectiveness of alternative service strategies for different types of abusers and neglectors. Clinicians at the project maintained complete records, on forms developed by BPA, on 1724 adult clients receiving treatment during 1975 and 1976, from the time of intake through termination. Data included: basic demographics, information on the nature and severity of the maltreatment, the amount and type of services received by the client, and outcome information including improvements in parents' functioning and reincidence of abuse or neglect. These data were first analyzed by project and for the whole demonstration effort using a variety of analysis techniques, to determine the relationships between client characteristics, services received and outcome. Then, data from other parts of the study, including case management and program management information, were included to determine the extent to which these other variables help explain outcome. Finally, data on service costs were used to determine the cost-effectiveness of alternative strategies.

Limitations

The evaluation's methodology was limited in a number of ways resulting in findings which are suggestive, not conclusive. The projects studied were selected because of the unique or different approaches they proposed to demonstrate, not becasue they were representative of other child abuse and neglect treatment programs across the country and thus findings cannot be generalized to all treatment programs in the field.

The methods and measures used were largely developmental -- this being the first study of its kind in the child abuse field. No control communities or control client groups were studied, and little exists in the literature that can be used for comparative purposes. Thus the findings must be interpreted with care. It must be recognized that they suggest possible directions for future child abuse and neglect treatment programs; they are not definitive, however.

During the summer of 1974, the projects began the lengthy process of hiring staff, finding space and generally implementing their planning programs. Concomitantly, BPA collected baseline data on each of the projects' community child abuse and neglect systems and completed design plans for the study. By January 1975, all but one of the projects was fully operational and all major data collection systems for the evaluation were in place. Through quarterly site visits to the projects and other data collection techniques, BPA monitored all of the projects' activities through April 1977, at which time the projects were in the process of shifting from demonstrations to ongoing service programs. Throughout this period, numerous documents describing project activities and preliminary findings were prepared by the evaluators.[1]

As a final step in the evaluation, information and insights gleened from across all study components were aggregated and analyzed to develop a set of policy-relevant recommendations for the future funding and operation of child abuse and neglect programs. This report presents those aggregated findings and recommendations.

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[1] See Appendix B for a listing of major evaluation reports and papers.

SECTION I:

A DESCRIPTION OF THE DEMONSTRATION PROJECTS AND THEIR ACTIVITIES

(A) Project Profiles

As a group, the projects demonstrated a variety of strategies for community-wide responses to the problems of abuse and neglect, as discussed in this section. The projects each provided a variety of treatment services for abusive and neglectful parents; they each used mixes of professionals and para-professionals in the provision of these services; they each utilized many different coordinative and educational strategies for working with their communities. Table I.1 provides some basic facts about the projects. While not an exhaustive set of alternatives, the rich variety within and across projects has provided the field with an opportunity to systematically study the relative merits of different methods for attacking the child abuse and neglect problem.

While the projects' as a group embraced similar goals, each project was also demonstrating one or two specific and unique strategies for working with abuse and neglect, as described below:

The Family Center: Adams County, Colorado

The Family Center, a protective services-based project housed in a separate dwelling, is noted for its demonstration of how to conduct intensive, thorough multidisciplinary intake and preliminary treatment of cases, which were then referred on to the central Child Protective Services staff for ongoing treatment. In addition, the Center created a treatment program for children, including a crisis nursery and play therapy.

Pro-Child: Arlington, Virginia

Pro-Child demonstrated methods for enhancing the capacity and effectiveness of a county protective services agency by expanding the number of social workers on the staff and adding certain ancillary workers such as a homemaker. A team of consultants, notably including a psychiatrist and a lawyer, were hired by the project to serve on a Multidisciplinary Diagnostic Review Team, as well as to provide consultation to individual workers.

TABLE I.1: SUMMARY FACTSHEET ON PROJECTS

Variable	Adams County	Arlington	Baton Rouge	Bayamon	Arkansas	Los Angeles	Neah Bay	St. Louis	St. Petersburg	Tacoma	Union County
Host Agency	CPS	CPS	CPS	CPS	CPS	Hospital	Tribal Council	Hospital	Private agency	Private agency	CPS
Annual Budget	$186,696	225,984	175,524	150,912	128,976	236,280	55,884	160,068	122,472	155,820	669,744
Average Caseload Size	26	179	82	70	73	9	8	40	18	42	294
Average No. Core Staff	13	15	10	9	7	12	3	6	6	8	25
Ave. No. Individuals Participating	47	22	14	12	134	23	5	73	55	110	29
Percent Time Spent On:											
Overhead Operations	20%	15	29	23	31	23	49	21	30	33	31
Community Activities	7%	5	17	35	14	7	23	8	29	35	6
Treatment Activities	66%	76	53	30	48	69	20	64	34	22	55
Research/ Evaluation	7%	4	1	12	7	1	8	7	7	10	8

The Child Protection Center: Baton Rouge, Louisiana

The Child Protection Center, a protective services-based agency, tested out a strategy for redefining protective services as a multidisciplinary concern by housing the project on hospital grounds and establishing closer formal linkages with the hospital including the half-time services of a pediatrician and immediate access of all CPC cases to the medical facilities.

The Child Abuse and Neglect Demonstration Unit: Bayamon, Puerto Rico

In a region where graduate level workers are rarely employed by protective services, this project demonstrated the benefits of establishing an ongoing treatment, under the auspices of protective services, staffed by highly trained social workers with the back-up of professional consultants to provide intensive services to the most difficult abuse and neglect cases

The Arkansas Child Abuse and Neglect Program: Arkansas

In Arkansas, the state social services agency contracted to SCAN, Inc., a private organization, to provide services to all identified abuse cases in select counties. SCAN, in turn, demonstrated methods by which a resource-poor state, like Arkansas, could expand its protective service capability by using lay therapists, supervised by SCAN staff, to provide services to those abuse cases.

The Family Care Center: Los Angeles, California

The concept behind the Family Care Center, a hospital-based program, was a demonstration of a residential therapeutic program for abused and neglected children with intensive day-time services for their parents.

The Child Development Center: Neah Bay, Washington

This Center, housed within the Tribal Council on the Makah Indian Reservation, demonstrated a strategy for developing a community-wide culturally based preventive program, working with all those on the reservation with parenting or family-related problems.

The Family Resource Center: St. Louis, Missouri

A free-standing agency with hospital affiliations, the Family Resource Center implemented a family-oriented treatment model which included therapeutic and support services to parents and children under the same roof. The services to children, in particular, were carefully tailored to match the specific needs of different aged children.

Parent and Child Effective Relations Project (PACER): St. Petersburg, Florida

Housed within the Pinellas County Juvenile Welfare Board, PACER sought to develop community services for abuse and neglect using a community organization model. PACER acted as a catalyst in the development of needed community services, such as Parent Education classes, which others could then adopt.

Panel for Family Living: Tacoma, Washington

The Panel, a volunteer-based private organization, demonstrated the ability of a broadly based multidisciplinary, and largely volunteer, program, to become the central provider of those training, education and coordinative activities needed in Pierce County.

The Union County Protective Services Demonstration Project: Union County, New Jersey

This project demonstrated methods to expand the resources available to protective services clients by contracting for a wide variety of purchased services from other public and, notably, private service agencies in the county.

The projects implemented the programs they intended to demonstrate with varying difficulty and in varying amounts of time (in as few as four months in Arlington and Baton Rouge and over 18 months in Neah Bay and Los Angeles). Critical determinants of this include: relationship of proposal writers with project administration; relationship of host agency to other community agencies; complexity of the proposed demonstration; and the degree to which the organizational framework for the project was in place when funding occurred.

(B) Project Goals and Project Activities

The range or scope of project goals were similar, embracing concerns for educating the general public and professionals about child abuse, helping to bring about a more coordinated community system and testing out some particular set of treatment strategies for abusive and neglectful families, although the steps or means established for accomplishing these goals varied.
For all projects, goals shifted during the first year as community needs and staff capabilities became more clearly defined; the shifts in goals resulted in more clear and realistic objectives. The amount of time required to clarify and stabilize goals may have been reduced with the assistance from the evaluators. In general, projects were more successful in accomplishing their community-oriented than their treatment-oriented goals.

The projects represent different ways in which child abuse and neglect service programs might be organized and the kinds of activities they might pursue, as shown on Table I.2. Six of the projects (Adams County, Arlington, Baton Rouge, Bayamon, Arkansas and Union County) were housed in protective service agencies; two in hospitals (Los Angeles and St. Louis); two in private agencies (St. Petersburg and Tacoma); and one in a tribal council (Neah Bay). Two of the projects served as the community-wide coordinating body for child abuse and neglect (Tacoma and St. Petersburg). While none of the projects focused on primary preventive services, all performed certain educational and coordinative activities that contribute to primary prevention. Two projects (Neah Bay and St. Petersburg) pursued secondary preventive services; the remainder focused on direct treatment services. Of those performing direct treatment, four (Adams County, Arlington, Los Angeles and St. Louis) provided services to both parents and children (of those, only three--all but Arlington--provided therapeutic services to children) and the remainder served only parents. Four of the projects used primarily professional workers (Arlington, Baton Rouge, Bayamon and Union County); two (Arkansas and Tacoma) represent primarily a lay or volunteer staff model; the remainder had mixed staffs.

(C) Organization and Management Styles and Staffing Patterns

While the projects themselves, given their demonstration status, were all relatively small, informal and unstable compared to most existing state and local social service agencies, one sees diversity among them on many organizational and management characteristics, as seen on Table I.3. Notable differences between projects include budget, staff and caseload sizes, the diversity of activities pursued, and the numbers of different disciplines or agencies actively involved with the project, the degree of formalization of job design, job flexibility, rule observation, and the degree to which general organizational or specific job-related decisions were centralized.

It is difficult to describe and compare staffing patterns and staff characteristics given the relatively small staff sizes, the high turnover rates and the constant flux in number and types of staff positions and program participants. Core staff sizes ranged from three to 25; the average number of individuals (including consultants and volunteers) participating in a project ranged from five to 134. The majority of staff members across

TABLE I.2: Dimensions of Models Projects Were Demonstrating and Salient Management Factors

Variable	Adams County	Arlington	Baton Rouge	Bayamon	Arkansas	Los Angeles	Neah Bay	St. Louis	St. Petersburg	Tacoma	Union County
Host Agency	CPS	CPS	CPS	CPS	CPS	Hospital	Tribal Council	Hospital	Private agency	Private Agency	CPS
Affiliation With Host Agency	Direct	Direct	Direct	Direct	Contractual	Direct	Direct	Indirect	Direct	Direct	Direct
Service Orientation	Treatment	Treatment	Treatment	Treatment	Treatment	Treatment	Secondary preventive	Treatment	Secondary preventive	Treatment	Treatment
Client Orientation	Parents & children	Parents & children	Parents	Parents	Parents	Families	Parents	Families	Parents	Parents	Parents

Variable	Adams County	Arlington	Baton Rouge	Bayamon	Arkansas	Los Angeles	Neah Bay	St. Louis	St. Petersburg	Tacoma	Union County
Size											
Staff size, including volunteers and consultants	Medium	Small	Small	Small	Large	Small	Small	Large	Medium	Large	Medium
Caseload size	Small	Large	Large	Large	Medium	Small	Small	Medium	Small	Medium	Large
Complexity											
Diversity of disciplines represented	Low	Moderate	Low	Low	Moderate	Low	Low	Moderate	Moderate	High	Moderate
Formalization											
Amount of flexibility in jobs	Low	High	High	Low	High	Low	Low	Low	High	High	Low
Rule observation	High	Low	Low	Low	Low	High	Low	Low	Medium	Low	Medium
Specificity of job descriptions	Medium	Medium	Medium	Medium	Medium	Medium	High	Medium	Low	Low	Medium
Formality of recruitment procedures	Formal	Formal	Formal	Informal	Formal	Informal	Formal	Formal	Informal	Formal	Formal
Centralization											
Who makes most organizational decisions?	Director	Director	Board/ host agency	Staff	Staff	Director	Host agency	Director	Board	Director	Board/ host agency
Who makes most job-specific decisions?	Supervisor	Supervisor	Supervisor	Supervisor	Supervisor	Worker	Director	Director	Director	Worker	Director
Number of staff supervised by treatment coordinator	10	7	5	11	16	3	3	15	21	12	4

KEY

Staff Size: small = under 25; medium = 25-55; large = 56+

Caseload Size: small = under 26; medium = 26-55; large = 56+

Complexity: low = under 5 disciplines; medium = 5-7 disciplines; large = 8+

Formalization scores based on responses to standardized scales.

TABLE I.3: Typical Average Monthly Service Volume[1]

	Adams County	Arlington	Baton Rouge	Bayamon	Arkansas	Los Angeles	Neah Bay[2]	St. Louis	St. Petersburg	Tacoma	Union County	Average Across Projects Providing Service
Caseload Size	26	179	83	70	73	9	8	40	18	42	294	77
Intakes/Initial Diagnosis	22	32	27	8	44	--	2	13	--	8	30	22
Cases with Court Activities	6	19	3	4	7	4	--	4	--	4	6	6
Multidisciplinary Team Case Reviews	38	6	6	2	10	4	--	--	--	3	49	14
Individual Counseling or Therapy Contacts	81	284	68	92	19	55	19	94	--	114	392	118
Lay Therapy Contacts	79	20	--	--	368	5	--	28	135	18	119	96
Family/Couples Counseling Sessions	26	32	--	34	--	4	--	27	--	58	53	33
Crisis Intervention Contacts	22	55	37	7	21	6	--	45	--	12	249	50
24 Hour Hotline Calls	--	12	--	--	--	--	--	12	--	--	--	12
Group Therapy Person Sessions	44	72	--	4	--	--	--	106	--	20	28	46
Parents Anonymous Person-Sessions	54	--	--	--	45	--	--	--	98	--	--	66
Day Care Child-Sessions	--	153	--	--	8	--	--	22	--	--	492	166
Crisis Nursery or Residential Care Child-Days	127	--	--	--	--	207	--	--	--	--	--	167
Child Development Program Child-Sessions	22	--	--	--	--	155	--	285	--	--	7	117
Child Play or Other Therapy Sessions	10	30	--	--	--	10	--	16	--	--	7	15
Homemaking Contacts	--	8	20	--	--	--	--	--	--	--	191	40
Babysitting Hours	--	222	--	--	--	--	--	87	15	--	11	84
Transportation Rides	14	293	19	--	114	42	--	423	--	--	148	150
Psychological & Other Tests	8	9	6	10	--	4	--	18	--	12	3	9
Follow-Up Contacts	5	11	4	--	4	6	--	5	--	10	3	6
Parent Education Person-Sessions	33	--	--	114	69	--	4	17	--	29	36	43

[1] Does not include services a project may have provided sporadically.

[2] By October 1976, Neah Bay also offered court-case activities, multidisciplinary team reviews and crisis intervention.

all projects were female. Some projects had a high proportion of professionally trained staff or staff with several years of experience in the field; others had very few. All projects used volunteers in a wide range of treatment, educational and support capacities. While volunteers were important additions to the projects, they did not come "free" but cost a project in terms of management, supervision and consultation time. Six projects (Arlington, Bayamon, Baton Rouge, Neah Bay, Tacoma and Union County) experienced a turnover in directors. Projects that hired new directors from existing staff (all but Baton Rouge and Tacoma) appeared to have many fewer problems of continuity and "down time" than projects that hired new directors from the outside. Because of the multiple demands on projects like these, treatment projects (including all but Bayamon and Neah Bay) benefited from sorting out the functions of directing a project from those of supervising the treatment activities into two separate staff positions (a project director and a direct services coordinator). Projects with active advisory boards (Arlington, Arkansas, St. Petersburg, Tacoma and Union County) had an easier time solving problems as they arose, or anticipating them in advance, than did projects without such boards.

(D) Project Resources and Activities

While the amount of time spent on various activities and the cost and magnitude or volume of the activities varied across projects,[1] the projects did pursue many of the same activities (see Table I.1, I.3, and I.4).

The demonstration projects as a group, staff by approximately 450 people (including volunteers), spent $2.21 million annually, which was matched by over $330,000 a year in donated resources. With an average of 800 cases in treatment per month over 2200 new cases were opened by the projects each year. Countless others received minimal, supportive services from the projects. Direct treatment services focused on the abusive or neglectful parent, with individual counseling being the most widely offered service, supplemented by crisis intervention,

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[1] See the Cost Report for a detailed discussion of the Methodology used and the findings.

TABLE I.4: PROJECT COSTS

	Average Across Projects	Adams County	Arlington	Baton Rouge	Bayamon	Jeff. Co Arkansas	Wash. Co Arkansas	Los Angeles	Neah Bay	St. Louis	St. Petersburg	Tacoma	Union County
Average Monthly Expenditures	$15,720	15,558	18,832	14,627	12,576	5,142	5,213	19,690	4,657	13,339	10,206	12,985	55,812
Average Cost/Hour	$ 7.50	5.00	9.50	8.25	11.00	3.25	4.00	5.25		9.00		7.75	11.00
Average Monthly Cost/Case	$ 225	598	105	176	180	120	174	2,188	582	333	851	309	190
Unit Costs of Select Services*													
Cost/Multidisciplinary Team Review	$ 54.75	25.00	137.00	125.50	189.00	54.75	76.75	31.75	--	--	--	98.00	51.25
Cost/Hour: Individual Counseling	$ 14.75	8.25	11.00	14.50	28.75	14.75	35.50	9.75	24.75	7.00	--	7.75	18.50
Cost/Hour: Lay Therapy	$ 7.25	7.75	7.75	--	--	4.50	5.75	--	--	10.50	8.50	17.00	10.50
Cost/Person: Group Therapy Session	$ 10.50	3.75	9.00	--	69.25	--	--	--	--	9.50	--	27.25	9.00
Cost/Person: Parent Education Session	$ 9.50	5.75	--	--	--	--	--	--	41.50	32.75	--	31.25	19.25
Cost/Ride: Transportation	$ 8.75	30.00	10.50	30.75	--	2.50	--	14.25	--	2.25	--	4.00	21.75

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*These figures have been adjusted to account for regional wage and price differences.

multidisciplinary team reveiw and lay therapy services. Fewer than 175 children received direct treatment services from the projects each year. However, over 50,000 professional and lay people annually received direct education or training in matters pertaining to child abuse and neglect.

On average 25% of a project's budget was used for community-oriented activities, 65% for direct treatment services and 10% for research. The allocation of project resources to different activities was quite stable during the period when projects were operational.

The unit costs of direct treatment services varied considerably with lay and group services being about the least expensive (with an across-project average of $7.25 per lay therapy counseling contact; $9.50 per person for a parent education class; $10.50 per person for a group therapy session). Individual counseling cost about twice as much as lay therapy counseling ($14.75 per contact). Multidisciplinary team reviews cost the projects an average $54.75 per review; however, when the volunteered time of consultatns is ascribed a dollar value, the cost per review rises to $125.50. Comparisons across projects revealed that projects with larger service volumes provided group services at lower unit costs; unit costs of individual-client services were not a reflection of service volume.

(E) The Families Served by the Projects

A study of the characteristics of the families served by the projects suggests that despite projects' specific intake of admissions criteria, which influenced to some extent the kinds of cases served, projects still ended up serving a variety of cases (see Table I.5). Projects found that many cases referred were accepted for treatment because they could not get services elsewhere, rather than because the parents had committed the kinds of abuse or neglect the project wanted to serve. Projects also realized that all cases are complex, changing over time such that a potential case becomes an actual case or an abusive parent develops neglectful patterns. This suggests that while projects may have decided to focus on a particular kind of case, caseloads could not be exclusive, and service offerings had to be flexible enough to meet the range of needs clients had.

Table I.5: Information on Cases Served by the Projects During 1975 and 1976[*]

Variable	Adams County	Arlington	Baton Rouge	Bayamon	Arkansas	St. Louis	Tacoma	Union County	All Cases
Source of Referral[**]									
Private physician	3%	2%	2%	--	11%	4%	7%	1%	3%
Hospital	15	5	17	4	14	19	17	19	14
Social service agency	12	13	11	75	12	35	20	17	19
School	21	22	27	3	11	1	5	15	16
Law enforcement	9	6	18	2	3	--	3	11	8
Court	--[***]	7	1	--	3	3	8	3	3
Parent	3	8	5	2	2	1	3	4	4
Sibling	1	1	--	--	1	--	--	--	.5
Relative	5	6	16	2	11	1	10	7	7
Acquaintance/neighbor	11	17	8	3	17	3	7	7	10
Self	11	7	2	4	6	33	26	5	9
Anonymous	4	3	5	--	9	--	1	2	3
Case Status									
Abuse established	29%	10%	42%	29%	37%	41%	34%	21%	26%
Neglect established	3	14	5	24	11	6	14	18	12
Type of Maltreatment									
Potential abuse/neglect only	46%	30%	9%	25%	15%	13%	18%	23%	28%
Emotional maltreatment only	8	21	6	22	11	17	19	14	14
Sexual abuse	5	2	14	2	4	1	2	5	4
Physical abuse	37	14	49	20	51	60	39	27	31
Physical neglect	4	31	18	28	11	4	16	28	20
Physical abuse and neglect	--	4	4	3	8	5	6	4	3
Severity of Case									
Serious assault on child	18%	24%	27%	42%	43%	37%	32%	33%	28%
Previous record/evidence of maltreatment	23%	29%	21%	63%	62%	32%	23%	32%	29%
Responsibility for Maltreatment									
Mother	47%	54%	50%	48%	52%	73%	49%	52%	52%
Father	31	20	35	25	25	12	16	22	24
Both	16	23	13	14	20	14	34	22	29
Other	6	3	3	13	2	1	1	5	5
Legal Actions Taken									
None	40%	38%	25%	44%	19%	19%	15%	30%	31%
Court hearing	11	7	10	1	15	12	33	5	10
Court supervision, child home	2	4	15	--	4	5	7	1	4
Temporary removal	5	3	15	1	4	4	43	7	8

(Legal Actions Taken continued on next page)

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[*] Individual statistics for Los Angeles and St. Petersburg clients have not been included because of the small number of cases on which we have data, 12 and 11, respectively; information on these cases has been included in calculations for the "Total" column. Individual statistics for Neah Bay clients have not been included because they were not made available to the evaluator. Numbers in any of the variable sets may not add to 100% owing to rounding.

[**] Numbers do not add to 100% since more than one category may have been checked for a given case.

[***] Indicates less than one-half percent.

Table I.5 continued

Variable	Adams County	Arlington	Baton Rouge	Bayamon	Arkansas	St. Louis	Tacoma	Union County	All Cases
Legal Actions Taken (continued)									
Foster care	6%	5%	6%	2%	9%	21%	18%	11%	9%
Permanent removal	--	<1	--	--	--	--	1	1	<1
Criminal action for adult	3	1	4	1	1	5	5	5	3
Reported to mandated agency	56	32	21	5	70	47	24	60	46
Reported to central registry	21	40	30	--	48	18	3	40	30
Information on Children									
Premature child	6%	4%	5%	1%	5%	8%	13%	4%	5%
Mentally retarded child	2	6	5	6	1	1	7	4	4
Physically handicapped child	4	3	2	10	5	4	4	3	4
Emotionally disturbed child	3	6	18	2	2	1	12	6	6
Adopted/foster child	4	8	1	1	4	8	4	4	5
Unwanted pregnancy	4	4	5	5	6	3	7	6	5
Information on Household: Composition									
Mother/mother substitute present	98%	76%	87%	100%	97%	98%	91%	98%	92%
Father/father substitute present	71	44	59	71	69	51	60	54	58
Families with one adult	25	39	32	23	22	36	36	37	31
Families with 3 or more adults	3	15	10	9	9	12	8	7	8
Average number children in family	2.3	2.0	2.6	3.3	2.3	2.3	2.5	2.7	2.4
Families with one child	27%	45%	26%	11%	32%	26%	33%	26%	30%
Families with 4 or more children	19	12	23	41	18	10	22	30	21
Families with pre-schoolers	78	57	66	83	89	97	88	65	73
Information on Household: Education									
Mother: post-high school	8%	23%	21%	19%	8%	24%	26%	10%	15%
Father: post-high school	19	34	25	40	21	28	26	15	23
No high school degree in family	58	50	73	63	67	41	70	71	61
Information on Household: Race/Ethnicity									
Mother: Caucasian	80%	69%	63%	48%	80%	56%	92%	42%	65%
Father: Caucasian	84	72	66	41	79	65	84	45	68
No minorities in family	75	66	59	38	78	55	81	39	59
Information on Household: Employment									
Mother employed	36%	49%	30%	27%	31%	22%	17%	27%	34%
Father employed	80	84	85	66	80	79	76	74	79
No employment in family	23	19	31	35	29	44	42	38	30
Information on Household: Income									
Average total family	$8100	$10,000	$7400	$5000	$5400	$5500	$6000	$7500	$7700
Income <$5500	42%	46%	57%	73%	77%	73%	69%	67%	56%
Income >$12,000	15	24	17	5	5	6	7	13	15
Information on Household: Age									
Average age of mothers	27 yr	32 yr	30 yr	31 yr	25 yr	26 yr	26 yr	31 yr	29 yr
Average age of fathers	31	36	33	39	29	30	28	36	33

Table I.5 continued

Variable	Adams County	Arlington	Baton Rouge	Bayamon	Arkansas	St. Louis	Tacoma	Union County	All Cases
Problems in Household Leading to Maltreatment*									
Marital	44%	38%	41%	58%	40%	44%	40%	33%	40%
Job related	21	20	24	8	18	18	24	10	18
Alcoholism	9	17	8	36	8	6	5	15	13
Drugs	4	8	2	3	4	5	7	8	6
Physical health	14	20	16	32	18	14	28	18	19
Mental health	29	34	24	38	23	31	13	29	29
New baby	11	8	11	7	17	9	23	9	11
Argument/physical fight	21	21	18	50	15	22	18	14	20
Financial problems	41	42	46	57	57	49	65	43	46
Mentally retarded parent	1	3	5	3	5	--	1	4	3
Pregnancy	4	2	2	2	6	6	5	4	4
Heavy continuous child care	32	21	39	38	39	56	51	27	33
Physical spouse abuse	12	10	10	23	11	10	10	7	11
Recent relocation	18	16	16	1	24	10	36	10	16
Abused as child	41	8	16	8	21	36	38	9	21
Normal discipline	26	12	14	20	31	21	31	19	21
Social isolation	35	28	15	14	38	50	19	24	29
N =	349	267	131	95	180	78	93	370	1686

*More than one item may have been checked for a given case.

The families the projects did serve differ from cases routinely handled by public protective services departments in that a somewhat greater proportion are physical abuse (as opposed to neglect) cases; and they tend to have somewhat larger families, higher educational levels and suffer from financial and health problems as well as social isolation. While household conflict is not as problematic among this population as it is with protective services cases in general, the study cases are more likely to have been abused as children (compare Tables I.5 and I.6).

The most frequently offered service was that of one-to-one counseling (including individual counseling and individual therapy). This service was most often complemented by crisis intervention, multidisciplinary team reviews, lay therapy, couples and family counseling as well as transportation and welfare assistance. All other services were offered to 15% or fewer of the clients. Clients, on average, received three different types of services, were in treatment six to seven months, and had contact with service providers about once a week. Approximately 30% of the clients received a service package which included lay services (lay therapy counseling and/or Parents Anonymous) along with other services. Only 12% received a group treatment package (including group therapy or parent education classes as well as other services); and over half (54%) received a social work model package (individual tratment and other services but no lay or group services).

Service receipt varied somewhat depending upon the type of maltreatment; those cases designated as serious (in terms of the severity of the assault on the child) were more likely to receive multidisciplinary team case review and crisis intervention. Some client characteristics appear to have been relevant in decisions to provide clients with certain mixes or models of services.

Approximately 30% of the cases in the study population were reported to have severely reabused or neglected their children while they were in treatment. By the end of treatment, 42% of the clients identified as likely repeaters at intake were reported to have reduced propensity for future abuse or neglect. A somewhat smaller percent were said to have improved somewhat in aspect of daily functioning indicated to be a problem at intake.

TABLE I.6:

Characteristics of Families Reported During 1976 from Thirty States on the National Reporting Form to the American Humane and Validated (unless otherwise stated)

*Source of Referral[a]	All Cases	Validated Cases
Private physician	2%	3%
Hospital	10%	13%
Social service agency	9%	9%
School	11%	15%
Law enforcement	11%	14%
Court	2%	2%
Parent	9%	8%
Sibling	1%	1%
Relative	13%	10%
Acquaintance/neighbor	18%	14%
Anonymous	6%	3%
Other agency	5%	5%
	N= 40,576	19,627

Simple Classification of Maltreatment	
Substantiated abuse	43%
Substantiated neglect	47%
Substantiated abuse and neglect	10%

Expanded Classification of Maltreatment	
Physical abuse	18%
Physical neglect	49%
Sexual abuse	3%
Emotional abuse/neglect	32%

Severity of Maltreatment for Involved Children	
No treatment	70%
Moderate	22%
Severe	8%
Serious[c]	30%

Legal Actions Taken for Involved Children	
Court ordered placement	8%
Permanent removal	<1%
Voluntary placement	8%

Information on Household	
One adult at home	39%
Mother: average age	25 yrs.
Father: average age	35 yrs.
Teenage parent in family	at least 15%
Mother: Caucasian	69%
Father: Caucasian	75%
Mother: high school degree	33%
Father: high school degree	41%
Mother: employed	30%
Father: employed	76%

Information on Household (continued)	
Income less than $5500	approximately 51%
Income more than $12,000	approximately 13%
Average family income	at least $6760
Families on public assistance	42%

Information on Children	
Average number children in household	1.7
Premature	2%
Mentally retarded	3%
Physically handicapped	3%
Emotionally disturbed	7%

Problems in Household Leading to Maltreatment[a,d]	
Marital problems	38%
Alcoholism	16%
Drugs	3%
Physical health problems	5%
Mental health problems	17%
New baby in home	12%
Argument/fight	35%
Financial difficulties	39%
Heavy, continuous child care responsibilities	26%
Physical spouse abuse	13%
Recent relocation	17%
Overcrowded housing	20%
History of abuse as child	10%
Normal method of discipline	9%
Social isolation	14%

[a] More than one item may be checked for a case; thus numbers will not add to 100%.

[b] Percents reported here reflect state reporting laws and not necessarily actual incidence.

[c] Serious includes: hospitalized, permanent disability or fatality.

[d] Based on 4,167 reports received by AH in 1975.

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*It is interesting to compare the AH source of reports for all cases and validated cases: clearly significant proportions of reports coming into protective service agencies from relatives, acquaintances and neighbors, as well as anonymously, are later found to be invalid cases, suggesting a tremendous need for more public awareness of what child abuse and child neglect are to reduce inappropriate referrals and thus inappropriate use of the protective service system. More specifically, of the 15,185 reports received from these sources, 9,881 or 65% were found invalid, as compared with only 44% of the reports from all other sources being found invalid.

(F) The Handling of Project Cases

As can be seen on Table I.7, patterns of case management varied across the projects. Norms across the projects in terms of case management suggest the following: of the cases studied across all projects more than one-half were contacted within three days of the initial report. Before coming to a decision on a plan of treatment for a client, usually at least one more meeting with the client in addition to the first contact was made; treatment services then would typically begin within two weeks of first contact with the client. Despite the interest and attention in the field to multidisciplinary review of cases, the typical case in the sample was not reviewed by a multidisciplinary review team at any time in the process. Use of outside consultants on the management of the case also was not the norm. On the other hand, whereas case conferences or staffings usually were not used on the case at intake or termination, there was a likelihood that such a conference was held sometime during the treatment phase of the case. The manager of the case was usually the person who also carried out the intake, and, further, the typical case had only one case manager. Other than the primary case manager there was likely to be at least one other person in the project working with the client and, at the same time, the client usually also received services from an outside agency. Evidence of communication and coordination with the source of the report and with outside treatment providers (if the client was receiving such services) was also the norm, but active client participation in treatment planning and reassessment was not the usual practice. While the case was open it was likely for the case manager to see the client about once or twice a month. After a case was terminated, usually some contact was made either with the client or with outside service providers regarding the current situation of the client.

(G) Community Activities

The communities in which the projects were located varied by size and key demographic characteristics as shown in Table I.8. These community characterisitcs did not seem to affect the implementation or short term operation of the projects as much as the nature of the local child abuse delivery system.[1]

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[1] See *Community* Systems Report for a full discussion of the projects' community activities and possible impacts on the community system.

TABLE I.7:

Case Management Practices: The Experience of the Joint Demonstrations*

The Practices	Adams Co.	Arlington	Baton Rouge	Bayamon	Arkansas	Los Angeles	St. Louis	Tacoma	Union Co.	Total
Time Between Referral and First Contact										
Same Day	63%	15%	33%	6%	16%	39%	31%	47%	39%	32%
1-3 Days	30%	17%	24%	6%	25%	23%	28%	5%	15%	19%
4-7 Days	3%	26%	9%	21%	14%	23%	7%	14%	2%	12%
Within 2 Weeks	3%	13%	9%	13%	23%	8%	12%	9%	6%	11%
Within 1 Month	3%	22%	6%	40%	10%	0	10%	20%	11%	14%
Over 1 Month	0	7%	19%	15%	13%	8%	12%	5%	28%	12%
Number of Client Contacts (After Initial Contact) Before Treatment Plan										
None	8%	36%	13%	22%	36%	7%	17%	59%	28%	27%
One	33%	36%	38%	28%	38%	0	37%	15%	36%	31%
Two	23%	16%	13%	27%	3%	39%	3%	18%	23%	17%
Three-Five	35%	9%	30%	21%	18%	15%	23%	8%	4%	18%
Over Five	3%	4%	7%	3%	5%	39%	20%	0	9%	7%
Time Between First Client Contact and First Treatment Service										
Within 2 Weeks	65%	71%	61%	68%	80%	92%	42%	69%	41%	68%
2 Weeks to 1 Month	27%	9%	3%	18%	17%	0	24%	22%	18%	16%
Over 1 Month	7%	18%	11%	15%	3%	8%	26%	5%	16%	13%
No Treatment Given	0	2%	25%	0	1%	0	8%	5%	25%	9%
Use of Multidisciplinary Review Team										
At Least 1 Review	100%	15%	27%	71%	18%	85%	17%	20%	14%	35%
Review During Intake	98%	3%	4%	13%	5%	77%	14%	16%	5%	21%
Review During Treatment	13%	12%	22%	64%	15%	75%	6%	16%	13%	21%
Review at Termination**	23%	1%	0	27%	6%	67%	0	2%	9%	7%

TABLE I.7 (continued)

The Practices	Adams Co.	Arlington	Baton Rouge	Bayamon	Arkansas	Los Angeles	St. Louis	Tacoma	Union Co.	Total
Use of Case Conferences (Staffings)										
At Least 1 Conference	47%	28%	42%	100%	93%	92%	95%	47%	54%	62%
Conference During Intake	5%	18%	20%	63%	64%	92%	79%	21%	31%	38%
Conference During Treatment	45%	17%	24%	97%	91%	92%	84%	43%	45%	55%
Conference at Termination**	19%	4%	16%	100%	63%	67%	38%	13%	41%	30%
Use of Consultants										
None	42%	57%	67%	37%	80%	8%	73%	91%	77%	62%
One	10%	9%	13%	12%	3%	0	4%	3%	4%	7%
Two	13%	15%	2%	9%	5%	0	5%	2%	0	6%
Three-Five	18%	12%	11%	24%	12%	8%	8%	14%	12%	13%
Over Five	18%	8%	7%	19%	0	85%	10%	2%	8%	11%
Client Participation										
Client Presence at MDT's and for Case Conferences	10%	9%	7%	0	5%	0	50%	22%	20%	14%
Contact with Referral Source										
For Background Information	93%	89%	84%	93%	73%	100%	55%	81%	89%	84%
For Progress Reports	72%	81%	49%	62%	45%	92%	63%	76%	82%	68%
Responsibility for Intake										
Current Case Manager	78%	47%	84%	62%	11%	85%	37%	77%	55%	58%
Other Staff Member	23%	53%	16%	38%	89%	15%	63%	23%	45%	42%
Number of Case Managers										
One	72%	95%	87%	75%	73%	85%	61%	80%	76%	78%
Two	23%	5%	13%	25%	21%	15%	26%	18%	17%	18%
More than Two	5%	0	0	0	6%	0	13%	2%	7%	4%
Reason for Two of More Case Managers										
Joint Management	N= 4	N= 0	N= 1	N= 0	N= 3	N= 1	N= 2	N= 0	N= 2	N= 13 (15%)
Staff Turnover	N= 5	N= 1	N= 2	N= 9	N= 2	N= 0	N= 7	N= 4	N= 5	N= 35 (40%)
Staff Unavailability	N= 0	N= 2	N= 3	N= 0	N= 3	N= 1	N= 0	N= 2	N= 2	N= 13 (15%)
Lack of Success with Client	N= 2	N= 0	N= 0	N= 0	N= 2	N= 0	N= 1	N= 1	N= 4	N= 10 (11%)
Other	N= 1	N= 0	N= 3	N= 0	N= 2	N= 0	N= 7	N= 1	N= 3	N= 17 (19%)

TABLE I.7 (continued)

The Practices	Adams Co.	Arlington	Baton Rouge	Bayamon	Arkansas	Los Angeles	St. Louis	Tacoma	Union Co.	Total
Number of Treatment Providers in Project (Other than Case Manager)										
None	39%	54%	32%	62%	57%	31%	15%	2%	45%	38%
One	30%	33%	27%	22%	10%	0	11%	27%	32%	24%
Two	22%	2%	21%	13%	21%	39%	32%	19%	21%	19%
Three-Five	10%	9%	20%	0	12%	23%	40%	50%	2%	18%
Over Five	0	2%	0	3%	0	8%	3%	2%	0	1%
Services from Outside Agencies	56%	59%	64%	46%	63%	85%	72%	80%	78%	66%
Evidence of Communication with Outside Agencies	86%	89%	93%	100%	65%	91%	78%	82%	89%	85%
	(N= 22)	(N= 27)	(N= 28)	(N= 16)	(N= 26)	(N= 11)	(N= 25)	(N= 32)	(N= 38)	(N= 224)
Frequency of Contact by Case Managers										
About Once Per Week or More	48%	26%	36%	23%	51%	70%	62%	41%	22%	39%
About Once or Twice Per Month	38%	57%	22%	58%	24%	15%	16%	27%	25%	33%
Less Than Once Per Month	2%	11%	2%	9%	5%	8%	3%	8%	14%	7%
Once/Twice Only	7%	4%	4%	3%	5%	8%	3%	13%	12%	7%
Varied Over Time	5%	2%	33%	6%	15%	0	13%	9%	18%	13%
None	0	0	2%	0	0	0%	3%	2%	10%	2%
Follow-Up Contacts**										
At Least One Contact	65%	61%	56%	60%	57%	67%	65%	35%	59%	56%
Contacts With Client										
Two or Less	78%	94%	93%	79%	90%	67%	92%	93%	88%	90%
Three to Five	13%	4%	4%	21%	9%	33%	8%	2%	12%	8%
Over Five	9%	2%	2%	0	1%	0	0	5%	0	2%
Length of Time in Treatment**										
Through 3 Months	0	13%	20%	0	15%	33%	8%	12%	12%	12%
4-12 Months	59%	76%	67%	54%	77%	67%	60%	74%	70%	69%
1-2 Years	41%	11%	13%	46%	9%	0	20%	14%	18%	18%
Over 2 Years	0	0	0	0	0	0	12%	0	0	1%
Total No. Cases Reviewed	40	46	45	35	41	13	38	45	51	354
Total No. Terminated Cases Reviewed	22	46	45	12	34	3	25	42	44	272

*Throughout, percentages may not sum to 100% owing to rounding.
**Terminated cases only.

TABLE I.8: Community Setting

Project	Definition and Size of Service Area	Population Size (1970)	Community Type	Population by Age (1970)			Family Income		
				Percent Under 1 Year	Percent 1-4 Yrs.	Percent 5-17 Yrs.	Percent Below Poverty	Percent Moderate-Middle	Percent Above $15,000
Adams County, Colorado	Adams County 1,246 sq. mi.	185,789	Suburban-rural	1.9%	8.0%	32.8%	5.7%	76.3%	18.0%
Arlington, Virginia	Arlington County 25.8 sq. mi.	174,284	Suburban	1.6%	5.2%	17.0%	3.7%	52.2%	44.1%
Baton Rouge, Louisiana	East Baton Rouge Parish	285,167	Urban-suburban-rural	1.9%	7.3%	27.7%	13.6%	65.5%	20.9%
Bayamon, Puerto Rico	Bayamon region, Bayamon & eight other cities	338,500*	Urban-suburban	2.0%	10.0%	32.0%	48.0%	49.0%	3.0%
Arkansas	Garland, Jefferson & Washington Counties**	216,830	Rural	1.7%	6.5%	24.4%	19.1%	71.6%	9.3%
Los Angeles, California	Southeast region of Los Angeles County--93.6 sq. mi.	763,000	Urban	2.2%	8.4%	Not Available			
Neah Bay, Washington	Makah Indian Reservation--43.8 sq. mi.	1,100*	Rural-Indian	Not Available					
St. Louis, Missouri	St. Louis City 61.4 sq. mi.	622,236	Urban	1.7%	6.3%	22.9%	26.5%	60.6%	12.9%
St. Petersburg, Florida	Pinellas County 280 sq. mi.	522,329	Urban-suburban	1.1%	4.1%	17.8%	9.0%	76.6%	14.4%
Tacoma, Washington	Pierce County	411,027	Urban-suburban-rural	1.7%	6.5%	25.9%	8.0%	72.0%	20.0%
Union County, New Jersey	Union County	543,116	Urban-suburban	1.4%	5.8%	24.0%	4.5%	59.4%	36.1%

*These data are from more recent population estimates than the 1970 Census, which was used for all other projects.

**The project maintained a unit in Garland County for 20 months of the demonstration period.

In response, no doubt, to national attention focused on the need for expanded training and education of professionals and lay citizens alike, and also in response to the perceived lack of such activities in their own communities, the demonstration projects directed a major portion of their non-service delivery efforts to providing training and education in the dynamics of abuse and neglect, the appropriate procedures for reporting suspected cases, and on the availability of community treatment resources.

The demonstration projects had mixed effects on their respective community child abuse and neglect systems, particularly when viewed from the perspective of appreciably increasing coordination among all community agencies, introducing the use of interdisciplinary staff, modifying the community's reporting and response system, developing new preventive and treatment services for parents and children on a community-wide basis, or improving the overall quality of case management for most cases in the system. The area in which the projects had the most success was in the provision of both professional and community education.

Attempts to better coordinate the respective efforts of all community agencies who have occasion to deal with child abuse and neglect cases invariably took the form of organizing community-wide multi-agency coordinating groups (councils or boards) and developing formal coordinative agreements with various agencies around the handling of specific case-management functions such as the reporting of cases, service planning, and case referral. In each community, except St. Louis, that did not have a multi-agency coordinating body prior to the demonstration project's implementation, such councils or boards were subsequently developed by the projects, often as Project Advisory Boards. Several of these, during the course of the three years, became autonomous from project sponsorship and developed into community-wide bodies in order to increase their visibility and leverage within the community.

Although there was no relationship between a given project's sponsorship (e.g., public agency or independent program) and its success in developing these coordinating bodies, there was definitely a relationship between sponsorship and a project's ability to stimulate formal coordinating agreements between agencies on a system-wide basis. Thus, those projects that were protective service agency-affiliated developed more coordinative agreements between themselves and other agencies than independent projects, and the communities in which these public agency projects were housed also evidenced an increase in coordination agreements among more non-project agencies than did the communities in which the demonstration project was an independent program.

The development of multi-disciplinary teams, either community-wide or agency-specific (project- or hospital-based teams) was the primary method of securing interdisciplinary input for case review and management, although several projects also hired staff or consultants of various disciplines to extend the primary social work orientation of most community systems. All project communities had some form of multidisciplinary team, although in only six communities were these teams available to review cases on a community-wide basis. Despite the problems projects had in implementing multidisciplinary teams, they were successful in pointing out to their respective communities the necessity of taking advantage of the expertise and skills of various professionals when dealing with child abuse and neglect problems, even if the specific mechanisms employed were only marginally successful.

Centralized reporting systems and 24-hour coverage for the receipt of reports, issues that have been prominent nationally for several years, appear to have been solved satisfactorily in each of the demonstration communities except one. Although in only seven communities has reporting been centralized in the local protective service agency, the remaining three communities with dual systems (e.g., reports may be made to two or more community agencies) have developed arrangements whereby the sharing of reports or referral of cases between agencies occurs smoothly. Twenty-four-hour coverage exists in nine communities; in eight of these, the after-hours systems were developed subsequent to demonstration projects' implementation and most often the projects were heavily involved in the system's development. In Bayamon, after-hours reports are still being handled by the police, a situation viewed as unsatisfactory by most observers.

State legislation is clearly the major input to development of a centralized reporting system, and most often, to the development of 24-hour coverage as well. Although several projects were able to provide after-hours coverage systems without legislative mandate, most communities develop adequate reporting and response systems only after state legislation requiring such systems has been approved.

Each of the demonstration projects substantially increased the amount and type of services that were available in their communities for dealing with abusive and neglectful parents through the development of their own treatment programs. However, they were generally unable to increase the provision of services to highrisk families or children. Three projects provided extensive therapeutic services for children, but to a small caseload, and one project developed a program of visiting parents of newborns to acquaint them with the community services available.

There was little proliferation of services for abused and neglected children and their parents by community agencies other than the projects, suggesting that the projects did not effect the provision of additional services by other agencies. The problems with developing such service increases appear to be both a lack of resources and commitment on the part of other agencies, and a pervasive attitude that with the development of the demonstration project, the problem of inadequate services was no longer a "system" problem, but was a "project" responsibility.

The demonstration projects were also unable to effect significant increases in the use of already existing community resources for child abuse and neglect clients, by other community agencies, and in only a few cases did the projects themselves make adequate use of existing resources. In particular, there was a noticeable lack of referrals to other community agencies, particularly private agencies, either at the point of initial service planning or later in the treatment process. Several projects consciously made efforts to utilize existing programs more adequately, in one case on a fee-for-service basis, but these were the exceptions rather than the rule.

Except for communities where the demonstration projects were housed in, or affiliated with, the local protective service agency, little change in the quality of case management, system-wide, was observed. The timing of responses to reports by the legally mandated agencies was generally good, with most reports responded to in two days or less. Several projects affiliated with CPS agencies developed special Intake Units which appeared to greatly facilitate adequate response to reports. The adequacy of case assignment, service planning and case monitoring, system-wide, remained much the same as it was prior to project's implementation, except in those few cases where multidisciplinary teams were instituted for case review and service planning. The projects themselves generally handled these functions more adequately than is seen in a protective service agency, but any carry-over to the remainder of the system was evident only in communities where the projects had an affiliation with the protective service agency and was thus in a position to actively promote changes. The termination and follow-up procedures of both community agencies and the demonstration projects were generally poor, and little change was observed during the demonstration period. Cases tended to be kept open longer than might be required, and were then terminated "in batches." Little follow-up of closed cases was carried out in the communities, although a few projects attempted to institute follow-up procedures for their own clients. The primary problems with regard to termination and follow-up appeared to be inattention to the importance of these functions on the part of supervisors and agency heads, a reluctance on the part of staff to take the responsibility for a possible premature termination, and a lack of staff resources to provide even minimal follow-up services for closed cases.

All of the projects provided extensive education and training to both professional and community residents, in the form of educational presentations and seminars, community speaking engagements, distribution of pamphlets and brochures and media coverage. This education and training, although mostly focused on professionals, reached a wide audience; between 3,000 and 28,000 people in each community were educated during the course of the demonstration. Although the education and training provided was extensive, most projects approached it in a less-than-planful fashion, primarily responding to requests rather than initiating the contacts, and rarely providing any "re-education." Despite the projects' educational efforts, and probably because of them, few other agencies or groups in these communities significantly increased the education they provided to either professionals or community groups, leaving in question who will retain the responsibility for child abuse and neglect education community-wide after the projects have phased out.

In summary, although community agencies report that the projects had success in modifying certain aspects of their community systems, such as increasing the knowledge and awareness of both professional and community residents and developing multi-agency coordinating bodies, they had mixed success, as a group, in other areas. The only project characteristic which appears to be associated with overall community impact is project affiliation, and then only for certain aspects of community impact. Thus, projects that were affiliated with the local protective service agency were more likely to be able to influence the development of coordinating agreements between agencies, provide new or innovative services to the majority of the community's child abuse and neglect cases, and improve the overall case-management function within the community than were independent projects. On the other hand, project affiliation had little to do with the development of coordinating councils or boards, the provision of interdisciplinary input into case decision-making or the provisions of education and training on a community-wide basis. The development of a centralized 24-hour reporting system was almost totally dependent on state legislation and, except for efforts to properly implement the legislation, was rarely impacted by the projects.

Although the projects did have significant success in correcting many of the deficiencies in the community systems, several problems consistently remain in the project communities at the end of the demonstration period. Coordination among both public and private agencies is inadequate; interdisciplinary input, while provided for in some cases, is not afforded the majority of the communities' cases; existing community resources have not been fully utilized in the provision of services; child neglect and high risk cases are provided minimal services; preventive services and therapeutic services for children are generally inadequate, and the case management function, particularly with respect to adherence to appropriate termination procedures and the provision of follow-up, is generally less than optimally carried out.

SECTION II:

MANAGEMENT OF PROGRAMS AND CASES

Central to the functioning and thus the performance of any child abuse and neglect service program is the way in which the overall program is managed and organized. Of particular concern are those organizational and management factors which influence individual worker attitudes and commitment to the job as well as the quality with which cases are managed. In the evaluation, a study was done of overall project management processes to determine which organizational, personnel and management processes contribute the most toward a positive work environment, an environment in which workers do not burn out.[1] In addition, a study was conducted of the case management processes at the projects to determine which case handling and case manager variables contribute the most toward quality case management. The findings from these two efforts are discussed in this section,[2] followed by an analysis of the relationships between management and program efficiency.

(A) Program Management and the Work Environment: The Causes of Worker Burnout[3]

In order to gain insights into those organizational, management and personnel factors that contribute toward a positive work environment and thus reduce the likelihood of worker burnout (workers becoming separated or withdrawn from the original meaning and purpose of their work, estranged from their clients, their co-workers, the agency they work for such that they cannot and do not perform well on the job), each of the eleven projects' management processes and the attitudes of all workers at the projects were studied in detail. After identifying worker characteristics, management descriptors and organizational structure descriptors at each of the projects, these sets of factors were studied independently in terms of their relationship with the degree to which workers were burnt out. The most salient worker, management and organizational variables were then considered in combination to determine which had the stronger effects on burnout. Findings must be interpreted with care; they represent the experiences of workers at eleven demonstration projects and not necessarily workers in the field in general.

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[1] See the Program Management Report for a detailed discussion of the methodology used and the findings.

[2] See the Quality of the Case Process Management Report for a detailed discussion of the methodology used and the findings.

[3] All analysis findings referred to but not presented in tables are available upon request.

Worker Characteristics and Burnout: Worker or personnel characteristics are those descriptors which differentiate between workers, including job title, supervisory responsibility, educational attainment, work experience, age and sex. As shown on Table II.1, burnout is more likely to occur among younger, inexperienced workers, male employees, full-time workers and among employees who are supervised by others.

Organizational Structure and Burnout: The organizational structure of a program is the framework by which a program operates, the blueprint of how personnel are arranged in relation to each other and to the task, such as the organization's size, complexity, formalization and centralization. As can be seen on Table II.1, larger caseload sizes, more formalization of rule observation (i.e., emphasis on adherence to rules), and more centralized decision making (i.e., lack of worker participation in decisions) are related to burnout.

Management Processes and Burnout: Management processes are those integrative functions that blend worker characteristics and organizational structures into an effective and efficient (or ineffective and inefficient) work environment. Management processes include: the quality of project leadership, the degree of innovation allowed or encouraged, the amount of clarity and autonomy in jobs as well as the amount of work pressure, the degree of communication among workers and the amount of staff support. As shown on Table II.1, presence of burnout is related to the following: non-supportive project leadership; untimely, inadequate or inappropriate communication; little or no emphasis on task orientation (i.e., lack of encouragement to "get the job done"); lack of clarity about management's expectations of workers; lack of worker autonomy; lack of innovation; and inadequate staff support or supervision. These findings strongly suggest that burnout is a function of poor program management processes.

Effects of Salient Worker, Organizational and Management Variables on Burnout: Having studied the bi-variate relationships between worker, organizational and management variables with burnout, the most salient or predictive variables from each group were studied together, using multivariate

TABLE II.1: Percent Distribution on Burnout and Worker, Organizational and Management Variables *

Age

Burnout	<24	25-30	31-40	41+
Burned out	44%	49%	39%	33%
Moderately burned out	35	27	29	29
Not burned out	22	24	33	38
Total	100%	100%	100%	100%

N=162

Not significant P = .74

Sex

Burnout	Male	Female
Burned out	59%	39%
Moderately burned out	22	30
Not burned out	19	30
Total	100%	100%

N=162

Not significant P .15

Months Employed in the Agency

Burnout	<12	13-24	25+
Burned out	39%	50%	23%
Moderately burned out	30	33	14
Not burned out	32	17	64

N=162

Significant P <.01

Supervisory Role

Burnout	Yes	No
Burned out	30%	49%
Moderately burned out	28	30
Not burned out	42	21
Total	100%	100%

N=161

Significant P <.05

Job Title

Burnout	Director	Management	Professional Service Provider	Para-professional service provider	Clerical	Other
Burned out	13%	48%	46%	25%	74%	50%
Moderately burned out	31	17	34	44	11	19
Not burned out	56	35	20	31	16	31
Total	100%	100%	100%	100%	100%	100%

N=162

Significant P <.01

Years Experience in Social Services

Burnout	<3	4-6	7-9	10+
Burned out	41%	54%	38%	31%
Moderately burned out	25	32	25	50
Not burned out	34	14	38	19
Total	100%	100%	100%	100%

N=162

Not significant P =.12

Degree

Burnout	None	AA	BA/BS	MA/MS/MSW	Other
Burned out	53%	38%	48%	37%	0
Moderately burned out	21	50	30	30	25
Not burned out	27	13	22	32	75
Total	100%	100%	100%	100%	100%

N=162

Not significant P= .23

*Chi-square used to determine statistical significance of raw numbers.

Table II.1: (continued)

Leadership

Burnout	Poor	Average	Good
Burned out	85%	48%	27%
Moderately burned out	15%	33%	33%
Not burned out	0	19%	39%
Total	100%	100%	100%

N=147 Significant P <.01

Innovation

Burnout	Poor	Average	Good
Burned out	69%	46%	27%
Moderately burned out	19%	31%	35%
Not burned out	11%	23%	38%
Total	100%	100%	100%

N=152 Significant P <.01

Involvement

Burnout	Poor	Average	Good
Burned out	67%	68%	30%
Moderately burned out	22%	19%	34%
Not burned out	11%	14%	36%
Total	100%	100%	100%

N=158 Significant P <.01

Task Orientation

Burnout	Poor	Average	Good
Burned out	70%	38%	27%
Moderately burned out	23%	31%	33%
Not burned out	8%	31%	39%
Total	100%	100%	100%

N=150 Significant P <.01

Job Clarity

Burnout	Poor	Average	Good
Burned out	57%	41%	26%
Moderately burned out	26%	41%	27%
Not burned out	17%	19%	39%
Total	100%	100%	100%

N=152 Significant P <.01

Communication

Burnout	Poor	Average	Good
Burned out	86%	51%	28%
Moderately burned out	14%	28%	34%
Not burned out	0	21%	38%
Total	100%	100%	100%

N=154 Significant P <.01

Staff Support

Burnout	Poor	Average	Good
Burned out	80%	41%	36%
Moderately burned out	15%	29%	31%
Not burned out	5%	29%	32%
Total	100%	100%	100%

N=156 Significant P <.01

Work Pressure

Burnout	Poor	Average	Good
Burned out	33%	38%	68%
Moderately burned out	25%	43%	23%
Not burned out	43%	19%	10%
Total	100%	100%	100%

N=162 Significant P <.01

Job Autonomy

Burnout	Poor	Average	Good
Burned out	81%	63%	27%
Moderately burned out	19%	31%	34%
Not burned out	0	6%	39%
Total	100%	100%	100%

N=156 Significant P <.01

Rule Observation

	Formalized Rule Observation		
Burnout	Low	Moderate	High
Burned out	24%	45%	42%
Moderately burned out	29%	45%	32%
Not burned out	47%	10%	26%
Total	100%	100%	100%

N=125

Significant P <.01

techniques to determine their relative effects on burnout. Supportive program leadership and worker age stand out as the most influential factors with respect to whether or not workers burn out. All of the following variables were found to have small effects (but not significant at the .05 level): amount and clarity of communication; whether or not a worker had supervisory responsibility; degree of innovation allowed; caseload size; the experience and sex of workers; and the degree to which rule observation was formalized.

Little related research currently exists, which could be used as a point of comparison for these findings. One of the few studies that can be used for comparative purposes supports the findings from this study, although worker alienation, rather than worker burnout, has the main focus. In a national study of social welfare and rehabilitation workers in 31 different agencies, conducted by Joseph Olmstead and Harold Christensen, the impacts of organizational structure, work climate, and individual attitudes on satisfaction, alienation as well as agency and individual performance were studied.[1] The major finding of the study was that work climate exerts a major impact upon work attitudes and work performance and is an even more potent factor in social service agencies than has been found to be true in conventional commercial and industrial organizations. The researchers conclude that work climate is the most important influence on alienation, satisfaction and performance, and thus worker burnout. Certain aspects of organizational structure impact upon work climate which in turn influences workers. For example, workers in larger organizations were more likely to be alienated. Further, it was found that younger workers are more likely to have a negative viewpoint about their agency and their work than older workers.

A recent study that focused directly on worker burnout, although not exclusively in the social service area, is that conducted by Christina Maslach.[2] Maslach studied 200 professionals in the helping professions and found burnout to be a major debilitating problem, confirming concern about this problem in the child abuse field. The research indicated that helpers are unable to cope with the continual emotional stress of relating to clients with problems; workers lose all concern, all emotional feelings for the person they work with and come to treat clients in detached and even dehumanizing ways. The result, says Maslach, is poor service delivery, low worker morale, absenteeism and high job turnover. Given that social service agencies cannot afford such conditions, Maslach's research focuses on understanding how workers can better cope with the stresses of work. Large caseload sizes, lack of diversity or flexibility in jobs, lack of sanctioned "time outs" and lack of informal peer support or communication all appear to be related to burnout. Although Maslach did not specifically assess organizational structure and management processes in the same way as in this evaluation study, her findings appear to confirm the importance of these factors in explaining burnout.

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[1] Olmstead and Christensen, 1973.

[2] Maslach, 1976.

It appears that burnout is not merely a function of a worker's own personal characteristics but also of the work environment. In order to avoid or diminish burnout among workers, and thus to enhance the longevity of worker and project performance, it would seem that a program needs to have quality leadership, clear communication, shared supervisory responsibility or supportive supervision, and smaller caseload sizes. A program should permit innovation as well as lack of adherence to certain formalized rules when it is in the best interest of clients. And programs should work carefully with younger, less experienced workers to help them avoid burnout.

(B) The Essential Elements of the Case Management Process[1]

In order to determine the feasibility of measuring the quality with which cases are managed and to begin to identify the essential elements of the case management process, a representative sample of case manager's cases at nine of the demonstration projects were studied with respect to the handling practices used, characteristics of the case manager, characteristics of the case and overall expert ratings of quality.[2] Data on over 350 cases were analyzed. In interpreting the results which follow, it must be kept in mind that this was largely a developmental effort, attempting to adopt, for the child abuse field, methods developed in the medical care field for assessing the quality of care. Findings are suggestive, not conclusive.

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[1] All analysis findings referred to but not displayed in tables are available upon request.

Elements of Quality Intake: Many programs choose to differentiate between intake and ongoing treatment by establishing separate units or identifying separate workers for each of the functions. It is therefore important to study intake separately to determine what the essential elements of case management are at this point in the treatment process. As shown on Table II.2, the most important case handling practices for quality intake are: contacting the case on the same day the report is received; meeting with the client frequently before developing a treatment plan; using multidisciplinary teams and outside consultants for diagnosis and treatment planning; recontacting the referral source for further background information on the case; and maintaining the same case manager for intake and ongoing treatment. The speed with which services are provided to a client after the first contact has an important, but statistically insignificant, relationship. With respect to case manager characteristics, case managers who are professionally trained, have had intensive training in child abuse and have worked with abuse and neglect cases for a number of years, tend to provide higher quality intakes. Of a variety of client descriptions, the clinician's view of client's responsiveness had the most to do with the quality of the intake. Contrary to what might be hypothesized, the seriousness or difficulty of the case does not influence the quality of intake management. As determined through the use of multivariate analysis techniques, the use of multidisciplinary team reviews appears to have the greatest effect on whether there was a higher quality intake. Other variables with significant effects include: less time between report and first client contact, use of more outside consultation, use of same case manager for intake and ongoing treatment, use of more highly educated and trained workers and more responsive clients.

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[2] The methodology used was adopted from the medical field, in which medical audits and peer review have become increasingly important. Notable works inlcude those of Brook (1973), Donabedian (1966) and Morehead (1971).

TABLE II.2:

Percent Distribution on Quality Intake Rating and Case Management Characteristics

	Quality Intake Rating	
	Lower	Higher
CASE HANDLING CHARACTERISTICS		
First client contact same day as report[a]	26%	42%
Treatment plan developed after only one or two contacts with client[c]	63	50
First treatment service within two weeks after first contact	65	74
Multidisciplinary Team used[a]	19	36
Outside consultants used[a]	28	53
Case Manager handled intake[a]	51	70
Reporting Source Contacted for background information[b]	80	91
CASE MANAGER CHARACTERISTICS		
Manager same ethnicity as client[b]	68	56
Manager similar SES to client	39	36
Manager same sex as client	63	69
Manager same age as client	17	19
Manager professionally trained[a]	65	81
Manager trained in child abuse/ neglect more than once[a]	57	79
Manager worked in field at least two years[a]	76	86
Manager responsible for over 20 cases	38	29
CASE CHARACTERISTICS		
Serious assault on child	39	41
Court involvement	24	32
Self-referral	11	11
Difficult Case from Manager's view	43	43
Client interested in treatment[a]	53	72
Client responsive to treatment[a]	53	73

a = Chi-square significant at $p < .01$
b = Chi-square significant at $p < .05$
c = Chi-square significant at $p < .10$

For this data set it appears that programs can enhance their intake processes by using their more highly qualified workers, responding quickly to reports, and ensuring that interdisciplinary input is used during the intake period. Use of a multidisciplinary team is most desirable, although perhaps not feasible for all new cases. Maintaining the same case manager throughout treatment also appears desirable, bringing into question the value of specialized intake units.

Elements of Overall Quality Care Management: Many case handling practices are related to high overall quality case management as shown on Table II.3. Contacting clients on the day the report is received, use of multidisciplinary teams and outside consultants, and contacting the referral source for background information on the case -- all factors associated with quality intakes, or also associated with the ratings of the quality of on-going management. In addition, frequent contact between the case manager and the client, keeping a case open for at least six months, and conducting follow-ups after termination are considered to be related to higher quality management. Getting clients into treatment quickly has a substantively important but insignificant relationship with quality. Of the range of case manager characteristics (see Table II.4), smaller caseloads and greater experience and training are associated with quality as is a difference in ethnicity between client and management. And, as was the finding with the associations of case descriptors and quality intake, cases of interested and responsive clients from the clinician's perspective received higher overall quality case management (Table II.5).

In order to begin to understand the relative effectiveness of these salient case handling, case manager and client descriptor variables with respect to expert ratings of overall quality case management, multivariate analysis techniques were used. Several characteristics appear as significant in predicting a high rating of overall quality: reduced time between report and first client contact, increase in the use of outside consultants, more frequent contact with the client, a longer time in process, responsiveness on the part of the client, and, interestingly enough, a difference in

TABLE II.3 *

Percent Distribution on Overall Quality and Case Handling Characteristics

	Lower Rating	Higher Rating
Time Between Report and First Client Contact (Any Type)		
Same Day	27%	46%
1-3 Days	19	19
4-7 Days	13	11
8-14 Days	11	9
15-30 Days	14	13
1-2 Months	11	1
Over 2 Months	5	1
(n = 332; significant at p<.01)		
Number of Contacts (Following First Contact) Prior to Decision on Treatment Plan		
None	30	19
One	30	35
2	17	17
3-5	17	21
Over 5	7	9
(n = 319; not signifiant)		
Time Between First Contact and First Treatment Service		
Within 2 Weeks	67	72
2 Weeks to 1 Month	20	13
Over 1 Month	14	15
(n = 304; not significant)		
Use of Multidisciplinary Review Team		
None	71	51
At Least Once	23	32
At Least Twice	6	17
(n = 342; significant at p<.01)		
Use of Case Conferences (Staffings)		
None	40	33
At Least Once	23	25
At Least Twice	23	26
At Least 3 Times	14	16
(n = 341; not significant)		

* Chi-square was used to determine the statistical significance of raw numbers.

(Table II.3 continued on following page)

Table II.3 (continued)

	Lower Rating	Higher Rating
Use of Outside Consultants		
None	69%	45%
Once	8	6
Twice	4	13
3-5 times	11	19
Over 5 times	8	20
(n = 344; significant at p<.01)		
Responsibility for Intake		
Current Case Manager	56	62
Other Staff Member	43	38
(n = 345; not significant)		
Number of Primary Case Managers		
One	78	78
Two	17	19
More Than 2	4	3
(n = 343; not significant)		
Number of Project Treatment Providers (Other Than Case Manager)		
None	40	34
1	25	19
2	17	26
3-5	18	21
More Than 5	1	1
(n = 344; significant at p<.1)		
Services Received from Other Agencies (or Individual)		
Yes	65	71
No	35	29
(n = 341; not significant)		
Communication with Other Service Providers		
Yes	82	91
No	18	9
(n = 221; not significant)		
Contacts with Reporting Source		
For Further Background		
Yes	80	93
No	20	7
(n = 302; significant at p<.05)		
Regarding Client's Progress		
Yes	65	74
No	35	26
(n = 300; not significant)		

(Table II.3 continued on following page)

Table II.3 (continued)

	Lower Rating	Higher Rating
Client Participation		
None	87%	81%
At Least Once	10	14
At Least Twice	2	5
At Least 3 Times	1	0
(n = 347; not significant)		
Frequency of Contact by Case Manager		
About Once a Week or More	36	50
About Once or Twice a Month	33	33
Less Than Once a Month	9	0
Once, Twice Only	9	2
Varied Over Time	12	15
(n = 339; significant at p<.01)		
Time in Process		
Through 3 Months	11	8
4 Through 6 Months	31	16
7 Through 9 Months	24	30
10 Through 12 Months	17	12
Over 12 Months	16	34
(n = 338; significant at p<.01)		
Follow-up Contacts		
None	54	31
One	34	32
Two	9	23
More Than 2	4	14
(n = 199; significant at p<.01)		

TABLE II.4

Percent Distribution on Overall Quality and Case Manager Characteristics

	Lower Rating	Higher Rating
Same Ethnicity as Client		
Yes	68%	52%
No	32	49
(n = 344; significant at p<.01)		
Similar Socio-Economic Experience		
Very Similar	5	12
Somewhat Similar	34	25
Not Very Similar	61	63
(n = 103; not significant)		
Same Sex as Client		
Yes	64	69
No	36	31
(n = 347; not significant)		
Similarity of Case Manager and Client Age		
Manager More Than 10 Years Older	23	21
Manager 3 to 10 Years Older	23	29
Manager Same Age (Within 2 Years)	19	17
Manager 3 to 10 Years Younger	20	23
Manager More Than 10 Years Younger	14	13
(n = 337; not significant)		
Age		
22-25	15	11
26-30	51	62
31-40	20	14
Over 40	16	15
(n = 345; not significant)		
Formal Education		
Professionally Trained	68	80
Not Professionally Trained	32	20
(n = 345; significant at p<.05)		
Training in Abuse and Neglect		
At Least Once	39	22
At Least Twice	26	38
At Least Three Times	20	18
At Least Four Times	15	21
(n = 345; significant at p<.05)		

(Table II.4 continued on following page)

Table II.4 (continued)

	Lower Rating	Higher Rating
Years Experience in Abuse and Neglect Treatment		
One Year or Less	23	12%
Two Years	33	21
Three Years	31	30
Four Years or More	14	37
(n = 336; significant at p<.01)		
Months Employed with the Project		
0-2 Months	16	20
3-4 Months	25	15
5-7 Months	23	16
8-10 Months	15	17
Over 10 Months	22	33
(n = 261; not significant)		
Caseload Size		
0-20 Cases	61	79
Over 20 Cases	39	21
(n = 345; significant at p<.01)		

TABLE II.5

Percent Distribution on Overall Quality and Case Characteristics

	Lower Rating	Higher Rating
Seriousness of Abuse and Neglect		
Serious	41%	36%
Less Serious	59	64
(n = 291; not significant)		
Court Involvement in Case		
Yes	27	28
No	73	72
(n = 340; not significant)		
Children Living Out of the Home		
Yes	29	33
No	71	67
(n = 335; not significant)		
Start of Case		
Before 1975	18	10
First Half of 1975	41	40
Second Half of 1975	36	42
After 1975	5	8
(n = 344; not significant)		
Type of Referral to the Project		
Self Referral	11	14
Referral from Other Agency or Individual	89	86
(n = 325; not significant)		
Responsibility for Case Management		
Project Primarily Responsible	86	84
Project Not Primarily Responsible	14	16
(n = 341; not significant)		
Difficulty of Case--Manager View		
Most Difficult	20	19
More Difficult	23	22
Average Difficulty	32	30
Less Difficult	13	17
Least Difficult	13	12
(n = 339; not significant)		

(Table II.5 continued on following page)

Table II.5 (continued)

	Lower Rating	Higher Rating
Client's Interest in Treatment		
Very Uninterested	18%	6%
Somewhat Uninterested	12	10
Neutral	15	10
Somewhat Interested	25	33
Very Interested	30	41
(n = 339; significant at p<.05)		
Client's Responsiveness to Treatment		
Very Unresponsive	19	7
Somewhat Unresponsive	12	8
Neutral	15	7
Somewhat Responsive	29	41
Very Responsive	26	38
(n = 340; significant at p<.01)		
Difficulty of Case--Assessor View		
More Difficult	85	84
Less Difficult	15	16
(n = 331; not significant)		

the ethnicity of the client and the manager. While not as significant, having notable effects on the quality rating are the following: contacting the reporting source for further background information on the case, use of multidisciplinary team reviews, and use of follow-up after termination. Each of these factors or variables that appear to help define a quality case management process are discussed below.

Immediacy of response to incoming reports. A minimal time lapse between report and first contact with the client is one of the most powerful predictors of both high quality intake and high overall quality case management. Those case managers that respond to incoming reports with a sense of urgency in order to intervene in a crisis or potential crisis situation set the tone for their future case management interactions with the client. While it seems evident that child maltreatment cases need immediate response, this is an area in which many agencies fall seriously short and programs should press harder to make early contact with prospective clients a high priority.

Recontacting the reporting source for further background information. This variable is associated with both intake and overall quality management. Contacting the reporting source for background information on the client and case dynamics is an indicator of both thoroughness of intake and communication with another service. Whether or not the reporting agency maintains an association with the client, this linkage is potentially useful in future management of other cases. Agencies with formal interagency agreements around management of cases encourage workers to open and maintain communication and, thereby, strengthen service delivery to clients.

Intensity of contact between client and case manager throughout the history of the case. With abuse and neglect cases, where the potential for crisis is high, routine interaction between client and case manager must be established and continued. Maintaining frequent contact with the client, one of the strongest indicators of high overall quality case management, suggests that the case manager is monitoring the client's progress in a systematic manner. Case managers should seek ways to maximize ongoing contact with the client and supervisors should encourage regular meetings between client and worker.

Use of multidisciplinary team reviews. The child abuse and neglect field has for sometime been encouraging the use of multidisciplinary reviews as a formal means for introducing a range of perspectives on diagnosis and treatment planning. It is interesting to note that the use of such team reviews on a case is a significant predictor of high quality intake and a somewhat lesser predictor of high overall quality case management. Multidisciplinary team reviews are important for case management because a sole worker or even a single agency cannot be expected to know all there is about managing many of the cases; such a team provides needed interdisciplinary input. At the same time, presenting cases to a multidisciplinary team encourages workers to thoroughly prepare their treatment plans and/or reassess their client's progress.

Use of outside consultation. Again, both intake and overall quality are very positively associated with use of consultants. Abuse and neglect cases are complex and often difficult to handle, and a case manager who recognizes this and uses available consultation, as necessary, is indicating awareness of the need to turn to other experts for assistance. Despite limited budgets, agencies should arrange for a panel of outside consultants to work with case managers and should encourage workers to use these resources.

Ongoing case manager also conducting the intake. Acknowledging that the field is divided over the issue of separation of intake and ongoing treatment, the data presented here supports, significantly, having the intake and ongoing treatment managed by the same person. Intake units appear to inject enough discontinuity in treatment provision so as to adversely affect quality case management. If intake workers were more highly trained and experienced, and the transfer process more efficient, perhaps these adverse effects could be mitigated.

A longer time in process. Cases that were only opened for short periods of time more often received lower ratings on the quality of overall case management. The inference is that short-term cases were handled too hastily and without rationally systematic procedures and practices. This is not to say that all cases should be open for longer periods, but that for those cases which appropriately should be closed after a short time, more care and attention is required.

Follow-up contacts after termination of the case. Completing the case management process by following-up after case closure, either by making a personal contact with the client or by contacting another agency still in touch with the client is an important aspect of overall quality case management. Many abuse and neglect agencies, while exhibiting strong case management practices for open cases, have been remiss in encouraging workers to make contact within a short period of time after termination, to assure that no new problems have emerged which require further intervention.

A few case manager characteristics are also significantly associated with judgments of high quality case management. This does not mean that these attributes in and of themselves cause higher quality, but that certain types of managers more often had cases which were rated of higher quality. The assumption is that these manager qualities lead to better management practices in those areas that are most associated with quality case management.

Years of experience in abuse/neglect treatment. This case manager characteristic has a very strong association with both high quality intake and overall case management, leading to the conclusion that problem-specific experience is critical in working with these difficult cases that have multiproblems and diverse needs. The implication of this finding for program managers is that, while it is not possible to hire only highly experienced workers (because of a severe shortage of this type of worker), and while other personal qualifications should enter into hiring decisions, looking for those with more direct experience is important.

Formal education of the case manager. It is clear that advanced formal education is not important for many aspects of working with abuse and neglect clients, such as for delivering certain treatment services. However, it appears that increased formal education better prepares a person for the demands of case management (or, perhaps, the same personality traits that cause one to seek more education make a person a better case manager.) Working with these cases can be learned, as evidenced by the strong association between experience and high case management quality, but many of the aspects of case planning, including diagnosis, and knowledge and coordination of alternative intervention strategies and resources, can often be more efficiently learned in school. Again, in searching out workers who will be good case managers, programs should strongly consider formal training, along with the range of other personal attributes.

Difference in ethnicity between client and case manager. Contrary to popular belief, workers managing abuse/neglect cases do not have to be the same ethnicity as their client in order to carry out good case management. In fact, it appears that a non-match in ethnicity, such as, black worker and white client or white worker and black client, is best for overall quality. The possibilities are that either the client, because of an inculcated sense of deference is more cooperative with a worker of a different ethnicity, affecting case management practices, or case managers of the same ethnicity as their clients make stronger demands, thus alienating the client/worker relationship.

Smaller caseload sizes. Smaller caseload sizes significantly affect the quality of overall case management. This finding supports the contention from those who have worked with abuse and neglect cases that there is a need to maintain smaller work loads than with other social service or protective services cases. Program administrators must continuously strive to keep caseloads of a reasonable size.

In contrast to those case practices and case manager characteristics that were shown to be relevant to ratings of higher quality case management, several variables or characteristics, which are thought by many in the field to be critical, did not prove to be associated (using both bivariate and multivariate analyses) with judgments of quality intake or of overall case management quality. This does not mean that these characteristics or attributes might not have been a factor in ratings of one or more of the seventeen individual measures of quality from which the composite quality measures were constructed, but they were not associated enough to be meaningful when looking at the whole of intake or overall management. The following are the variables which were *not* useful in predicting perceptions of quality:

- Time between first contact and first treatment service
- Receipt of service from outside agencies or individuals
- Communication with other service providers
- Use of case conferences
- Recontacts with the reporting source regarding client's progress in treatment
- Client participation in treatment planning

- Number of primary case managers
- Agency responsibility for case management
- Seriousness of the abuse/neglect
- Whether the child was out of the home during treatment
- Type of referral (self-referral or not)
- Having the case manager the same sex or of a similar age as the client
- Case manager's length of employment with the project.

(C) Management and Program Efficiency

Analyzing the essential elements of good program and case management is important in order to understand how to best operate a program. The degree to which a program is operating well can be measured in a number of ways, including its effectiveness, its efficiency and even the degree to which workers are burnt out. While not a primary concern of this evaluation study, it is possible to utilize data collected on individual project resource allocations to develop relative cost efficiency ratings for each project and test the assumption that the essential elements of management are associated with efficiency.[1] The results of such a test must remain suggestive given the small number of projects (eleven).

A cost-efficiency rating was developed for each project by computing the ratio of a project's costs for its service package (i.e, the treatment services the project delivered) to the average costs for these services across all projects.[2] The relationships between the projects' efficiency scores and project and case management characteristics were studied.

The organizational properties found to be most significantly associated with efficiency (at $p < .02$) were: staff size (the larger the staff), span of control (the wider the span of control, i.e., the fewer the number of supervisors) and clarity of rules (the more explicit the rules and procedures). This is to say, larger projects without many levels of authority but with clearly specified rules, among the demonstration projects, were the more efficient ones. Although these organizational factors are not necessarily unfavorable to high job morale, they are not the variables most conducive to job satisfaction. Rather, the work climate processes most highly associated with job satisfaction (e.g., job autonomy, staff support, opportunities to be innovative and creative) tend to increase the cost of administering the program, thereby reducing program efficiency. Indeed, one sees a strong, negative association between cost efficiency and job satisfaction. The quality of case management, on the other hand, has a positive, significant, although small association with efficiency, indicating the importance of good case management for efficient project operation.

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[1] The relationships between costs and effectiveness are discussed in Section III.

[2] For a detailed explanation of the methodology and findings, see the Cost Report.

Factors with less significant but substantively interesting relationships with efficiency include: lack of bureaucratization, decentralized decision-making, and small monthly caseload sizes. In addition, projects utilizing many different disciplines and projects that are organizationally complex, in that they pursue a number of different activities and work with many different agencies, tend to be more efficient. In other words, diversity within a program is good; formal structure and size are not necessarily so.

In conclusion, there would appear to be certain trade-offs between cost efficiency and how a program is organized and managed: In the more efficient project, workers may be less satisfied. The factors which contribute toward efficiency are different from those that contribute toward job satisfaction, and they are often incompatible.

SECTION III.

TREATING ABUSIVE AND NEGLECTFUL PARENTS

Practitioners and theorists alike advocate certain services as being the most effective for abusive and neglectful parents. In this, the first large-scale comparative child abuse and neglect treatment outcome study, their views are tested to determine the relative effects of different service strategies. Insights into the relative strength or influence of different treatment services and case handling techniques for different types of clients will be most useful to policy makers, program planners and program managers alike in maximizing the utilization of scarce resources and the benefits of child abuse and neglect delivery systems. In order to gain such insights, 1724 abusive and neglectful parents served by the demonstration projects are studied in detail.[1] The resultant findings are limited in a number of ways. The data collected comes from projects selected because of the different, unique strategies they proposed to demonstration and not because they are representative of child abuse treatment programs across the country. Thus, the findings are not generalizable to all treatment programs. The findings are further limited by the following: no control client groups were studied; no data were gathered directly from clients; and no follow-up after treatment services were completed was conducted.

After looking at outcome in general for the population served by the individual projects and the whole demonstration program, the influence of discrete treatment services (e.g., individual counseling, group therapy, lay therapy) and service mixes (e.g., a group treatment model) are studied in relation to several differrent measures of client outcome to identify the more effective services. Characteristics of the client (e.g., age, income level, type of maltreatment committed) are taken into account to see if they, in any way, influence treatment outcome. Select aspects of case handling practices (e.g., frequency of contact, case manager's caseload size, length of time in treatment) are also studied to assess their importance in success with clients. Finally, the costs associated with different treatment strategies are linked with outcome to establish the cost effectiveness of alternative treatment approaches.

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[1] See the Adult Client Report for a detailed discussion of the methodology used and the analyses conducted.

(A) The Impact of the Demonstration Projects on Their Clients

Several different measures of impact or outcome were used in this study, including: the presence or absence of severe reincidence of abuse or neglect while a client was in treatment (including serious physical abuse or neglect and sexual abuse); improvement during treatment on a number of indicators of client functioning theorized to be related to one's potential for abuse or neglect; a composite score of improvement on those aspects of client functioning indicated to be a problem at intake and clinical assessments of the overall reduction in propensity for future abuse or neglect by the end of treatment for those clients identified as likely repeaters at intake.

In this study, it was found that 30% of the clients served by the demonstration projects exhibited severe reincidence of abuse or neglect while they were in treatment, and that 42% (many of whom were reported with severe reincidence) were reported with reduced propensity by the end of treatment. Success was slightly higher with physical abuse (46%) and serious cases (43%) than with other cases (e.g. physical neglect 37%, sexual abuse 38%, emotional abuse/neglect 39%), but the success rate with different kinds of clients based on other descriptors is basically the same in terms of propensity for future problems. With respect to specific aspects of daily functioning, success rates of less than 30% were seen on individual measures, with less than 40% of the clients improving in at least one-third of those areas identified as problems at intake (see Table III.1).

Table III.1

Percent Distribution of Outcome Scores for Select Measures

	ADAMS COUNTY	ARLINGTON	BATON ROUGE	BAYAMON	ARKANSAS	ST. LOUIS	TACOMA	UNION COUNTY	TOTAL
Reduced propensity for abuse or neglect	49% (n=121)	41% (n=186)	48% (n=96)	43% (n=123)	56% (n=169)	25% (n=81)	58% (n=93)	29% (n=321)	42% (n=1208)
Severe reincidence during treatment	19 (167)	13 (324)	32 (162)	35 (177)	51 (207)	22 (98)	17 (113)	36 (456)	30 (1724)

*Individual statistics for Los Angeles and St. Petersburg clients have not been included because of the small number of cases on which we have data; information on these cases has been included in the calculations of the "Total" column.

Table III.1 Continued

	ADAMS COUNTY (n=154)	ARLINGTON (n=295)	BATON ROUGE (n=154)	BAYAMON (n=143)	ARKANSAS (n=196)	ST. LOUIS (n=96)	TACOMA (n=107)	UNION COUNTY (n=429)	TOTAL (n=1594)
A little (improved on 0.33% of those areas identified as problem at intake)	66%	70%	59%	66%	51%	71%	53%	59%	62%
Some (improved on 34-66%)	15	14	18	21	22	17	26	17	18
A lot (improved on 67-100%)	19	16	23	13	27	13	21	24	21

Table III.1 Continued

FUNCTIONING INDICATORS	ADAMS COUNTY (n=156)	ARLINGTON (n=297)	BATON ROUGE (n=155)	BAYAMON (n=143)	ARKANSAS (n=194)	ST. LOUIS (n=96)	TACOMA (n=105)	UNION COUNTY (n=448)	TOTAL (n=1613)
GENERAL HEALTH	10%	11%	7%	18%	14%	10%	23%	13%	13%
STRESS FROM LIVING SITUATION	30	29	28	21	35	24	18	30	28
SENSE OF CHILD AS PERSON	26	16	18	19	28	26	41	18	22
BEHAVIOR TOWARD CHILD	31	20	27	34	35	25	37	26	28
AWARENESS OF CHILD DEVELOPMENT	28	16	19	22	31	15	31	22	23
ABILITY TO TALK OUT PROBLEMS	24	15	19	24	35	30	43	25	25
REACTION OF CRISIS SITUATION	23	20	19	24	34	16	31	22	23
WAY ANGER IS EXPRESSED	16	18	17	18	30	16	28	19	20
SENSE OF INDEPENDENCE	21	11	16	15	25	16	36	17	18
UNDERSTANDING OF SELF	19	10	19	14	30	23	36	17	19
SELF ESTEEM	21	9	19	15	29	17	31	17	19

On the other hand, there are important variations in success across projects. Several projects --Arkansas and Tacoma-- had much higher overall success rates (56% to 58% of clients with reduced propensity) than other projects (25% to 49%). Arkansas additionally had the highest severe reincidence in treatment rate (56% compared to 25-49% at other projects). The more successful projects were uniquely characterized within the overall demonstration program by their emphasis on use of lay and group services as part of a complete treatment package. These lay and group services allow for more client contact, and likely more in-depth contact, which may account for their effectiveness. In contrast, those projects which overall had the least success were characterized by an emphasis on the more traditional kinds of service strategies (albeit intensively and comprehensively delivered) normally associated with Protective Services agencies, as well as larger worker caseloads which inhibit the amount of time a worker can devote to any one client.

It is difficult to pass judgment on the demonstration program's overall success with these statistics. Certainly, the recurrence of severe abuse or neglect, particularly while a client is in treatment, suggests that the child was not being sufficiently protected. That 30% of the client's children experienced such maltreatment, or lack of protection, does not speak highly of the project's initial intervention strategies, which is additionally a reflection of the lack of sophistication of intervention strategies in general. And even if the 42% of the cases reported with reduced propensity for future abuse or neglect are indeed clients who will not maltreat their children in the future (indicating that the projects may have made a valuable service contribution toward alleviating child abuse and neglect problems) this is not the kind of success rate many would like to see. It would be useful, given this seemingly disappointing finding, to compare the projects' success rates with those of other programs. Comparision data is not easily found, however.

Evaluation of treatment services for abusive and neglectful parents constitutes a major gap in the child abuse and neglect literature. The literature in the field primarily consists of studies concerned with: medically identifying abuse and neglect; distinguishing child abuse from neglect; differentiating both actual and potential abusers and neglectors from non-abusers and non-neglectors; determining the causes of abuse and neglect;

assessing the incidence and prevalence of abuse and neglect in the population.[1] As such, the existing literature provides very few benchmarks or comparative points for the current study's findings. A few often cited studies in which the results of treatment programs are discussed do exist. Of these, only a few give any quantitative results.[2]

First, a series of studies were conducted over several years by the faculty and students at the University of Pennsylvania School of Social Welfare, assessing the experience of families receiving social work counseling services by the Philadelphia Society to Protect Children (PSPC).[3] The focus of the study was the neglectful parent. Impact was measured by whether or not a family returned for services after termination. This measure of impact is of questionable utility; some clients may have continued to neglect their children, but simply may not have returned to the PSPC. However, the recidivism rate found was close to 60% and it was additionally found that the families' problems had changed little since their first contact with the agency. This does suggest the program may have had a 40% success rate, comparable to that found in the current study.

Second, a study was done by the Denver, Colorado Protective Services Program which provides intensive child welfare worker services to abusers and neglectors (including a range of advocacy and counseling services).[4] Social workers, in this study, were asked to describe what kinds of positive changes the parents had gone through during treatment. Impacts were expressed in terms of specific behaviors or problems: 22% of the families were reported as having improved in home care, 39% of the families improved in child care, 80% of the children were no longer in danger of subsequent abuse. This 80% may be contrasted with the 41% figure with reduced propensity in the current study. The amount and type of services and the differentiations between abusive and neglectful families were not specified in this Colorado effort.

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[1] A sampling of these works include: Helfer and Kempe, 1968 and 1972; Light, 1973; Newberger, 1973; Gil, 1970; Cohen, 1974; Spinetta and Rigler, 1972; Silver, 1968; Polansky, et al., 1972; Pavenstedt, 1967; Kadushin, 1974; Zalba, 1967.

[2] None of these studies have used a rigorous experimental design, clinical trials, cost-benefit or cost-effectiveness analysis or any other techniques which meet the criteria of rigorous evaluative research, although some of the newer research activities approach this. In addition, these studies are characterized by a number of other problems which limit comparisons, notably: data collection procedures are relaxed, with reliance on clinical judgments rather than standardized measures; sample sizes are small; samples are drawn from specialized populations; clients exhibiting a wide range of behaviors are included without specification of the nature or severity of abuse/neglect committed; and impact is not differentiated on the basis of kind or amount of service received but rather length of time in treatment and a generic description of the service package provided.

[3] Lewis, 1969.

[4] Johnson and Morse, 1968.

Among a number of descriptive case studies of small treatment efforts which begin to consider treatment in an evaluative but non-quantitative way are analyses of programs in Boston, Denver, New York and Chicago. Bean[1] and Gladston[2] both describe the impacts of the Parents Center Project, a treatment program in Boston that provides therapeutic and supportive services including day care, group therapy and social work counseling to a caseload of 30-35 abusive parents and their children. Both studies report impressive program achievements based on clinical observation of cases. The reincidence rate was less than 20%. Parents were said to be more controlled, less isolated and better able to cope with the stresses of daily living. There is, however, no quantitative support for these findings, and thus comparisons with our own findings are not possible.

Davoren[3] and Steele and Pollock[4] describe the results of a multidisciplinary team study of a group of 60 parents in the Denver area. Supportive services such as social worker home visits were offered to the parents, but in addition the program provided a round-the-clock supportive service in the form of a friend to talk to. Members of the team became integral parts of the clients' lives. On the basis of clinical judgments (developed through informal interviews, home visits and psychiatric diagnoses), the researchers determined that the program's major impacts on clients came in reducing their isolation, providing a supportive system in which to function,

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[1] Bean, 1971.

[2] Galdston, 1970.

[3] Davoren, 1968.

[4] Steele and Pollock, 1968.

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encouraging them to learn how to reach out for help, and aiding them to care better for their children. The study findings, by the researcher's own admission, have questionable applicability:

> Our study group of parents is not to be thought of as useful for statistical proof of any concepts. It was not picked by a valid sampling technique nor is it a "total population." It is representative only of a group of parents who had attacked children and who came by rather "accidental" means under our care.... The duration of our contact (with cases) varied. A few parents were seen for only brief exploratory, diagnostic interviews. Most parents were seen over a period of many months, several for as long as three to five years.
>
> Steele and Pollock, 1968, pp. 104-5.

Fontana and his colleagues at the New York Foundling Hospital's Temporary Shelter Home Program describe their program, which provides residential care for 15 abusive mothers and their children for six months, during which time intensive therapy, child management and homemaking classes and other supportive services are provided.[1] Following this live-in period, services are provided on an outpatient basis for six additional months. After two years of operation, the program was assessed as successful with a near zero reincidence and recidivism rate. This is a marked contrast with the current study's severe reincidence rate of 30% while in treatment.

The Juvenile Protective Association in Chicago reports the results of a million dollar, six year, federally funded program, the Bowen Center Program which demonstrated the use of innovative child protective services for 35 abusive or neglectful families.[2] Prior to describing the project outcomes, the authors state:

> In the major human services--mental health, corrections, child welfare--there are not accepted measurement tech-

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[1] Fontana, et al., unpublished reports.

[2] Juvenile Protective Association, 1975.

> niques for any of the three factors (which must be studied to determine impact).... The question of "results" must of necessity be answered in terms of clinical judgment and, again, case description.

Following this, case-by-case vignettes are provided describing clinicians' assessments of how families improved in parent functioning and children's progress. Overall, the findings suggest that some families "improved" a lot and others a little, and that these improvements seem to be correlated with length of time in treatment and intensity of service (variables also found to be significant in the current study). Improvements occurred mainly in child care and household management. A follow-up, four years after treatment, was conducted on 13 of the cases. Numbers here are clearly too small for generalization.

The Child Abuse Project at the Presbyterian University of Pennsylvania Medical Center, using behavior modification treatment techniques, studied 41 families in which abuse had occurred or was considered likely, one year after treatment services began. Fully 84% of the families were rated by some observable indicator as having improved.[1] In the current study, a comparable percent improved in at least one area determined to be problematic at intake --however, it is not known whether the percents of clients improving in specific areas were the same, nor what the overall improvement rate among the Pennsylvania clients was.

The work of Dr. Eli Newberger and his colleagues in Boston contributes to knowledge in this area. More than 200 child abuse/neglect cases that have come to the attention of the Boston Children's Hospital have been included in a matched-sample study, in order to clarify the principal problems of the abuser or neglector and their implications for treatment. The research staff included a team of advocates who provided multi-advocacy services to clients over time. Significant changes in client functioning, largely from environmental and sociological perspectives, were measured. Interviews with clients were held at the time the case was identified in the hospital and at some period thereafter. Early research reports indicate that approximately 60% of the clients improved in select aspects of family functioning.[1] Once again, it is not known what the "overall success" rate of this program is.

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[1] Tracy, Ballard and Clark, 1975.

Parents Anonymous, Redondo Beach, California, has completed a parent evaluation of Parents Anonymous chapters across the country.[2] Parents reported improved self-esteem, reduced isolation and improved ability to cope with stress as a result of participation in Parents Anonymous. The longer a parent participated, the greater the reported improvement. While greater proportions of parents reported improvement in these areas of functioning than was reported for clients receiving Parents Anonymous (or any other treatment) in the current study, the findings do nicely parallel each other, and support the current study's finding of the importance of Parents Anonymous and length of time in treatment.

Finally, Berkeley Planning Associates completed an evaluation in 1975 of the Extended Family Center (EFC) in San Francisco, a federally funded demonstration providing therapeutic and supportive services to both abusive parents and their children.[3] Thirty-nine percent of the clients served by the Extended Family Center were reported with low propensity for future maltreatment; 55% of clients served by San Francisco Protective Services who were included as a comparison group in the study were reported with low propensity. While the measures used in this evaluation were not identical to those used in the current evaluation, they are similar enough for comparative purposes, leading to the conclusion that the success rates for the EFC program are the same as those for the projects in the current study.

Conclusions cannot be drawn about the overall success of the demonstration projects relative to most other programs that have been evaluated to date, given the paucity of comparable data. The findings from this current study can, however, be used as benchmarks for future studies. The findings do suggest that child protection programs, working with abusive and neglectful parents, cannot expect to have 100% success rates, and indeed, success with close to half of one's clients may be all that a program can look forward to, and that programs must seek ways to more effectively intervene at the outset of treatment to protect the child in order to avoid severe reincicence during treatment. The findings also suggest that the field may find it more beneficial to divert some of its resources away from treatment and explore in greater depth preventive strategies that might diminish the initial occurrence of maltreatment.

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[1] Daniel and Hyde, 1975.

[2] Lieber and Baker, 1976.

[3] Armstrong, Cohn and Collignon, 1975.

(B) The Relative Effectiveness of Alternative Treatment Strategies[1]

The relative effectiveness of alternative treatment strategies is first studied by looking at the presence or absence of severe reincidence while in treatment for different clients and then by considering a summary measure of treatment outcome, reduced propensity for future abuse or neglect by the end of treatment.[2]

(1) Reincidence While in Treatment

"Reincidence while in treatment" as an outcome measure suggests the success of projects in intervening in family situations early and intensively enough to prevent further occurrence of maltreatment. While individual clients may well be successes by the end of treatment even if they re-abuse or continue to neglect their children during treatment, and thus "reincidence while in treatment" cannot serve as a proxy measure of final treatment outcome, it is a measure with utility. Identification of the characteristics of those clients who re-abuse or continue to neglect can be useful in developing treatment plans. Identification of the services received by these clients is interesting but less useful. There is not, after all, a clear causal relationship between service receipt and reincidence. While clients receiving a particular service may re-abuse or neglect because of the inadequacy or inappropriateness of the service they are receiving, it is also plausible that clients begin to receive a particular service because there has been reincidence, or that the client was receiving a service precisely because clinicians perceived a high likelihood of reincidence.

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[1] All analysis findings referred to but not presented in tables are available upon request.

[2] Findings discussed reflect the overall demonstration experience. Individual project experiences, which do not differ frequently from the overall experience, are discussed in the Adult Client Report.

Table III.2

Percent Distribution of Clients with Severe Reincidence by Select Client Characteristics

	TYPE OF MALTREATMENT						SERIOUSNESS OF ASSAULT		SEVERITY				
	POTENTIAL ABUSE OR NEGLECT	EMOTIONAL MALTREATMENT	SEXUAL ABUSE	PHYSICAL ABUSE	PHYSICAL NEGLECT	PHYSICAL ABUSE & NEGLECT	SERIOUS CASE	NON-SERIOUS CASE	NOT SEVERE 0	1	2	3	SEVERE 4
ADAMS COUNTY	10% (n=41)	--	25% (n=8)	23% (n=107)	--	--	40% (n=65)	5%* (n=102)	3% (n=31)	7% (n=46)	19% (n=58)	52% (n=27)	40%* (n=5)
ARLINGTON	3 (97)	5% (n=58)	20 (5)	21 (44)	24% (n=92)	22%* (n=9)	31 (81)	7* (243)	4 (137)	12 (105)	25 (56)	22 (18)	63* (8)
BATON ROUGE	--	13 (8)	63 (24)	33 (81)	26 (23)	20* (5)	55 (62)	17* (100)	16 (37)	23 (66)	47 (47)	70 (10)	50* (2)
BAYAMON	--	28 (36)	--	42 (31)	48 (48)	100* (6)	60 (75)	16* (102)	21 (44)	14 (36)	32 (44)	56 (25)	68* (28)
ARKANSAS	9 (35)	48 (21)	70 (10)	56 (105)	72 (18)	73* (15)	85 (87)	26* (120)	17 (58)	59 (63)	64 (58)	67 (21)	100* (7)
ST. LOUIS	--	26 (19)	--	27 (59)	--	25 (4)	32 (38)	17 (60)	7 (28)	25 (24)	27 (22)	33 (18)	33 (6)
TACOMA	13 (15)	28 (18)	33 (3)	17 (42)	14 (14)	--	19 (42)	16 (71)	3 (35)	21 (24)	27 (37)	22 (9)	13 (8)
UNION COUNTY	13 (106)	30 (57)	95 (19)	43 (121)	46 (116)	63* (19)	70 (162)	18* (294)	11 (158)	31 (128)	59 (104)	72 (53)	77* (13)
TOTAL	7 (359)	24 (226)	60 (73)	36 (605)	37 (318)	51* (67)	56 (622)	15* (1102)	10 (530)	25 (499)	42 (433)	55 (183)	62* (79)

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*Chi-Square significant at less than or equal to .05.

**Individual statistics Los Angeles or St. Petersburg have not been included because of the small number of cases on which we have data, 13 and 7, respectively; information on these cases has been included in the calculations of the "Total" row.

Table III.2 Continued

	ALL CASES	PRESCHOOL CHILDREN		TEENAGE PARENT		MINORITIES		NO ADULT EMPLOYED		FOUR OR MORE CHILDREN	
		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
ADAMS COUNTY	19% (n=167)	20% (n=121)	13% (n=39)	12% (n=41)	21% (n=126)	10% (n=40)	21% (n=127)	14% (n=29)	20% (n=138)	14% (n=29)	20 (n=1
ARLINGTON	13 (324)	15 (172)	11 (126)	15 (158)	109 (166)	15 (113)	11 (211)	15 (62)	12 (262)	11 (38)	13 (28
BATON ROUGE	32 (162)	28 (96)	38 (48)	22 (63)	37 (99)	30 (66)	32 (96)	35 (43)	30 (119)	24 (37)	34 (12
BAYAMON	35 (177)	34 (110)	14 (29)	47 (45)	30 (132)	41 (123)	20* (54)	41 (54)	32 (123)	42 (69)	30 (10
ARKANSAS	51 (207)	49 (181)	70 (20)	59 (98)	43* (109)	77 (39)	45* (168)	62 (60)	46 (147)	56 (39)	49 (16
ST. LOUIS	22 (98)	23 (79)	--	21 (48)	24 (50)	27 (41)	19 (57)	18 (38)	25 (60)	30 (10)	22 (88
TACOMA	17 (113)	15 (91)	33 (12)	92 (64)	27 (49)	13 (23)	18 (90)	20 (45)	15 (68)	17 (24)	17 (89
UNION COUNTY	36 (456)	41 (289)	28* (153)	38 (190)	35 (266)	40 (263)	32 (193)	42 (151)	34 (305)	39 (135)	36 (32
TOTAL	30 (1724)	31 (1154)	24* (430)	30 (719)	29 (1005)	26 (1003)	34* (721)	35 (489)	27* (1235)	34 (333)	28 (134

* Chi-square significant at less than or equal to .05.

Table III.2 Continued.

	FAMILY CONFLICT		SUBSTANCE ABUSE		SOCIALLY ISOLATED		PARENT ABUSED AS CHILD		HEAVY CHILD CARE RESPONSIBILITIES		LEGAL INTERVENTION	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
ADAMS COUNTY	20% (n=59)	18% (n=108)	8% (n=26)	21% (n=144)	21% (n=70)	17% (n=97)	21% (n=91)	16% (n=296)	16% (n=31)	19% (n=136)	20% (n=138)	14% (n=29
ARLINGTON	15 (82)	12 (242)	17 (84)	11 (240)	14 (96)	12 (228)	29 (28)	11 (296)	10 (30)	13 (294)	16 (148)	10 (175)
BATON ROUGE	38 (37)	30 (125)	56 (16)	29* (146)	22 (27)	33 (135)	53 (30)	27 (132)	15 (20)	34 (142)	32 (85)	30 (76)
BAYMON	39 (100)	29 (77)	35 (75)	34 (102)	61 (23)	31 (154)	62 (13)	32 (164)	67 (15)	32 (162)	59 (27)	30* (148)
ARKANSAS	69 (32)	47* (175)	65 (20)	49 (187)	45 (73)	54 (134)	53 (45)	50 (162)	44 (52)	53 (155)	50 (159)	54 (48)
ST. LOUIS	36 (25)	18 (73)	20 (10)	23 (88)	25 (49)	20 (49)	23 (40)	22 (58)	13 (15)	24 (83)	26 (57)	18 (40)
TACOMA	25 (32)	14 (81)	43 (14)	13* (99)	13 (24)	18 (89)	17 (35)	17 (78)	21 (34)	15 (79)	17 (75)	14 (35)
UNION COUNTY	43 (88)	35 (368)	42 (95)	35 (361)	39 (107)	36 (349)	56 (43)	34 (413)	43 (56)	36 (400)	36 (349)	37 (102)
TOTAL	35 (464)	28* (1260)	33 (344)	29 (1380)	31 (256)	29 (1468)	30 (479)	29 (1245)	36 (332)	28* (1392)	32 (1054)	25* (657)

* Chi-square significant at less than or equal to .05.

For analysis purposes, the presence or absence of severe reincidence (including the more serious forms of physical abuse or neglect and sexual abuse) is the measure used. The relationships between client characteristics and severe reincidence while in treatment as well as type of service receipt and reincidence were studied.

The client characteristics examined include: age of children; age of parents; race; employment; size of family; amount of family conflict; presence of substance abuse; degree of social isolation; history of abuse as a child; presence of special child care responsibilities; presence of legal intervention; and total family income, as well as the type of maltreatment, the seriousness of the maltreatment, and the general severity of the family situation. As can be seen on Table III.2, which displays bivariate relationships between reincidence and client characteristics, most client characteristics are not highly associated with reincidence. The type of abuse or neglect that brought the case into treatment in the first place and the seriousness of that maltreatment, however, are useful predictors in whether or not there will be reincidence. Clients who have physically abused and neglected their children, sexual abusers, and serious cases are all much more likely to severely re-abuse or neglect during treatment. Parents who seriously abused or neglected prior to treatment are much more likely to continue to do so once in treatment.

As a more complete check on the relationships between select client characteristics and severe reincidence while in treatment, multivariate analysis techniques were used. This allowed for understanding the combined effects of client descriptors and the effects of each when the others are controlled for. Seriousness of assault was found to have the largest effect on whether or not there is severe reincidence while in treatment. This confirms earlier findings that seriousness of assault is the one select client descriptor, apart from type of maltreatment committed, that can be used to predict reincidence while in treatment.

The services examined included each of the discrete services offered by the projects (e.g., individual counseling, group therapy, specialized [alcohol/drug] counseling), as well as select service mixes including: the lay model, consisting of a combination of lay therapy and/or Parents Anonymous with other services; the group model, containing group therapy and/or parent education and other services but not lay services; and the social work model, consisting of individual counseling and other services but no lay or group services.

Keeping in mind that 30% of all cases in the data set were reported with severe reincidence, it was found that significantly different and larger proportions of clients receiving the following services were reported with reincidence than were those not receiving the service: specialized (alcohol, drug) counseling (57%), family planning (51%), crisis intervention (41%), child services (41%), homemaking (40%), welfare assistance (40%), lay therapy counseling (39%), transportation or babysitting (36%), and multidisciplinary team review (33%). For no service did a significantly different but smaller proportion of cases receive the service but re-abuse or neglect; i.e., no service appeared as one which potentially "curbed" reincidence. When looking at individual project data, only in Arlington was receipt of a service -- couples or family counseling -- significantly related to a lack of reincidence. Within each project, receipt of two or three different services was significantly related to the presence of reincidence. The only service significant at more than three projects was crisis intervention. (It can be hypothesized that this service is frequently provided as a result of reincidence while in treatment, or certainly as a result of a family's cry for help which may result in reincidence.)

It is difficult to interpret meaningfully the relationship between individual services and reincidence for many reasons, not the least of which is that services are rarely offered in isolation but rather as part of a service package. It is thus useful to study the relationships between service packages or service models and reincidence. When considering service receipt in terms of service models, it is apparent that clients receiving lay services as part of the service package were most likely to have severe reincidence (38% vs. 29% or less receiving other service models). This suggests that in terms of the overall demonstration experience, cases handled in part by lay persons were less likely to receive the kind of intense supervision early on that may help avoid reincidence. It was also found that more frequent contact and delivery of more services were both related to reincidence, suggesting that projects provided more intense service to those predicted to be repeaters or those that in fact were.

Despite the fact that many significant relationships were found between service receipt and reincidence, the proportional difference between serious and non-serious cases in terms of reincidence (56% to 15%) was greater than for any given service, for the whole data set.

In order to better understand the associations between service receipt and severe reincidence while in treatment, multivariate analyses were conducted (notably multiple regression). Of particular concern is the relative effect of receipt of each discrete service when other services are controlled for and the relative effect of each service model when others are controlled for. Specialized counseling was the discrete service found to have the largest effect on (or relationship to) whether or not there is severe reincidence.[1] Services with small but significant effects include parent education class (a negative relationship), crisis intervention and welfare assistance. It was also found that the probability of service reincidence was greater for those who received a service package including lay services than for those receiving other service packages. These relationships support the earlier findings.

(2) Reduced Propensity for Future Abuse or Neglect by the End of Treatment

As a summary measure of outcome, clinicians were asked to address whether or not clients who were identified at intake as likely repeaters had reduced propensity for future abuse or neglect by the end of treatment. Clinicians considered a broad range of behaviors and attitudes exhibited by the client as well as the client's life situation in making this judgment.

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[1] A positive relationship implies that severe reincidence is more likely to occur for clients receiving the service.

While this measure is a simple, in fact most rudimentary one, it does serve as a barometer of clinicians' views about treatment effect. Limitations of the findings must, of course, be kept in mind because of the nature of this outcome measure. Relationships between client characteristics and service provision variables with reduced propensity are studied to define the relative effectiveness of different treatment strategies.[1]

(a) Relationships between client characteristics and reduced propensity: Before exploring the complex relationships between client characteristics, service provision and reduced propensity, it is important to determine which, if any, of a variety of salient client characteristics are related to this outcome. Do some kinds of people do well in treatment programs irrespective of the nature and quality of services offered? Is it possible to predict the success of treatment on the basis of client characteristics alone? And, which client characteristics might be most useful in explaining or interpreting effectiveness of different mixes of services?

To address these questions the relationships between client characteristics identified earlier to be the most salient and least redundant and this summary outcome were studied. The overall finding is that client characteristics are not highly associated with the summary outcome measure.

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[1] In addition to the summary outcome measure, a composite score of improvement in those areas of client functioning identified as problems at intake was studied as a dependent measure in relation to client characteristics and service receipt. The following was learned: clients who both physically abuse and neglect their children, emotional maltreaters and clients with severe household situations (including a history of abuse and neglect) are less likely to improve on the functioning indicators used in this study. Other client descriptors have either very small or no relationship to whether or not such improvement is reported. Clients who are in treatment for at least six months and clients who received lay services (lay therapy counseling or "Parents Anonymous) are the clients most likely to show improved functioning by the end of treatment. While no one discrete service stands out as having a strong effect on this outcome when others are controlled for, the lay service model (receipt of lay therapy and/or Parents Anonymous) does have the strongest effect on improvement in each of the select areas of functioning, followed by the group model. Client descriptors contribute somewhat to interpreting this outcome. These findings are presented in detail in the Adult Client Report.

As shown on Table III.3, the type of maltreatment that brought a case to the projects is not highly related to reduced propensity for maltreatment. A range of 16% difference in improvement exists between the different types, with the smallest proportion of those who both physically abused and neglected their children and the largest proportion of physical abusers improving. Seriousness of the assault does not appear to have significant predictive or explanatory power with respect to reduced propensity although the severity of the family's situation has an interesting relationship. Of the range of other client descriptors, none appear to have a substantially interesting relationship with reduced propensity.

As a further check on the relationship between select client characteristics and the summary outcome measure -- reduced propensity for future abuse or neglect -- multivariate analysis techniques were used. No client characteristics were found to have a meaningful effect on whether or not propensity would be reduced.

(b) Relationships between reduced propensity for abuse and neglect and service receipt: To the extent that individual services on their own produce or result in treatment effectiveness, one would expect to see significant relationships between service receipt and reduced propensity. As shown in Table III.4, 42% of all cases were reported with reduced propensity; comparable proportions were seen for serious and non-serious cases. Looking across services, significantly greater percents of clients receiving lay therapy (52%) were thought to have reduced propensity. This pattern is further emphasized when considering service model receipt and propensity. As seen on Table III.4, 53% of those receiving lay services as part of their service package were reported with reduced propensity; whereas less than 40% of those receiving the group service model or the individual counseling model were so reported. Also, it is seen that the longer the client is in treatment, the more likely it is that the client had reduced propensity. Fourteen percent more of those clients in treatment over six months had reduced propensity, than those in treatment a shorter period of time.

Table III.3

Percent Distribution of Clients with Reduced Propensity by Select Client Characteristics

	TYPE OF MALTREATMENT						SERIOUSNESS OF ASSAULT		SEVERITY				
	POTENTIAL ABUSE & NEGLECT	EMOTIONAL MALTREATMENT	SEXUAL ABUSE	PHYSICAL ABUSE	PHYSICAL NEGLECT	PHYSICAL ABUSE & NEGLECT	NON-SERIOUS	SERIOUS	NOT SEVERE 0	1	2	3	SEVERE 4
ADAMS COUNTY (49%)	43% (n=30)	60% (n=5)	50% (n=4)	49% (n=78)	67% (n=3)	--	43% (n=47)	53% (n=74)	59% (n=22)	53% (n=32)	56% (n=41)	27% (n=22)	--*
ARLINGTON (41%)	50 (50)	36 (31)	25 (4)	56 (25)	36 (62)	25 (n=8)	39 (59)	42 (127)	42 (65)	44 (57)	37 (41)	40 (15)	38 (n=8)
BATON ROUGE (48%)	67 (9)	--	50 (14)	52 (46)	47 (15)	--	53 (36)	45 (60)	53 (19)	47 (43)	36 (25)	75 (8)	100 (1)
BAYAMON (43%)	44 (23)	52 (25)	67 (3)	39 (23)	34 (35)	33 (6)	36 (61)	50 (62)	56 (27)	44 (18)	46 (33)	25 (20)	40 (25)
ARKANSAS (56%	72 (25)	45 (20)	63 (8)	55 (82)	47 (17)	50 (14)	44 (71)	65* (98)	71 (45)	52 (54)	51 (45)	53 (19)	33 (6)
ST. LOUIS (25%)	40 (10)	14 (14)	--	29 (49)	--	--	28 (32)	22 (49)	23 (22)	19 (21)	11 (18)	50 (16)	25 (4)
TACOMA (58%)	67 (12)	69 (13)	67 (3)	53 (38)	58 (12)	50 (8)	57 (37)	59 (56)	62 (26)	57 (21)	53 (32)	63 (8)	67 (6)
UNION COUNTY (29%)	21 (70)	36 (45)	--	38 (86)	34 (83)	15* (13)	30 (112)	29 (209)	25 (114)	33 (86)	32 (71)	28 (40)	30 (10)
TOTAL (42%)	44 (230)	39 (160)	38 (50)	46 (440)	37 (230)	30 (57)	43 (743)	39 (465)	43 (342)	43 (337)	41 (313)	39 (150)	36 (66)

*Chi-square significant at less than or equal to .05.

** Individual statistics for Los Angeles and St. Petersburg have not been included because of the small number of cases on which we have data, 13 and 7, respectively; information on these cases has been included in calculations for the "Total" row.

Table III.3 Continued

	CLIENT CHARACTERISTICS											
	PRESCHOOL CHILDREN		TEENAGE PARENT		MINORITIES		NO ADULT EMPLOYED		FOUR OR MORE CHILDREN		ONE ADULT IN HOUSEHOLD	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
ADAMS COUNTY	49% (n=88)	44% (n=27)	55% (n=31)	47% (n=90)	41% (n=90)	71%* (n=31)	50% (n=24)	49% (n=97)	45% (n=20)	50% (n=101)	63% (n=16)	47% (n=105)
ARLINGTON	43 (106)	40 (63)	33 (92)	50* (94)	41 (122)	41 (64)	47 (36)	39 (150)	29 (24)	43 (162)	38 (60)	42 (126)
BATON ROUGE	46 (57)	52 (29)	49 (41)	47 (56)	50 (58)	45 (38)	48 (29)	48 (67)	45 (20)	49 (76)	54 (26)	46 (70)
BAYAMON	37 (75)	53 (19)	57 (35)	38 (88)	52 (44)	38 (79)	42 (43)	44 (80)	39 (51)	46 (72)	42 (24)	43 (99)
ARKANSAS	56 (142)	69 (16)	46 (87)	67* (82)	62 (135)	32* (34)	46 (52)	61 (117)	63 (35)	55 (134)	55 (29)	56 (140)
ST. LOUIS	25 (68)	--	35 (41)	15 (40)	23 (47)	27 (34)	17 (30)	29 (51)	33 (9)	24 (72)	24 (25)	25 (56)
TACOMA	56 (76)	46 (11)	62 (53)	53 (40)	56 (78)	67 (15)	59 (39)	57 (54)	50 (22)	61 (71)	58 (26)	58 (67)
UNION COUNTY	28 (213)	32 (99)	30 (141)	29 (180)	24 (136)	34 (185)	31 (118)	29 (203)	28 (101)	30 (220)	35 (104)	27 (217)
TOTAL	42 (843)	40 (267)	40 (531)	43 (677)	44 (717)	39 (419)	40 (377)	42 (831)	38 (284)	43 (924)	42 (315)	41 (893)

*Chi-square significant at less than or equal to .05.

Table III. 3 Continued.

	CLIENT CHARACTERISTICS											
	FAMILY CONFLICT		SUBSTANCE ABUSE		SOCIALLY ISOLATED		PARENT ABUSED AS CHILD		HEAVY CHILD CARE RESPONSIBILITY		LEGAL INTERVENTION	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
ADAMS COUNTY	42% (n=43)	53% (n=78)	35% (n=17)	51% (n=104)	44% (n=57)	53% (n=64)	47% (n=73)	52% (n=48)	46% (n=26)	30% (n=95)	52% (n=99)	36% (n=22)
ARLINGTON	44 (57)	40 (129)	37 (54)	42 (132)	41 (63)	41 (123)	39 (23)	41 (19)	53 (19)	40 (167)	35 (84)	46 (101)
BATON ROUGE	47 (19)	48 (77)	20 (10)	51 (86)	47 (17)	48 (79)	52 (23)	47 (73)	46 (11)	48 (85)	55 (51)	39 (44)
BAYAMON	33 (66)	54* (57)	33 (55)	52 (68)	39 (18)	44 (105)	18 (11)	46 (112)	55 (11)	42 (112)	44 (18)	43 (103)
ARKANSAS	48 (25)	58 (144)	56 (18)	56 (151)	48 (63)	61 (106)	51 (35)	58 (134)	58 (43)	56 (126)	53 (131)	68 (38)
ST. LOUIS	33 (21)	22 (60)	38 (8)	23 (73)	26 (39)	24 (42)	27 (30)	24 (51)	15 (13)	27 (68)	21 (47)	27 (33)
TACOMA	57 (28)	59 (65)	92 (12)	53* (81)	73 (22)	54 (71)	63 (27)	56 (66)	59 (29)	58 (64)	56 (63)	63 (27)
UNION COUNTY	23 (66)	31 (255)	28 (69)	30 (252)	37 (73)	27 (248)	32 (28)	39 (293)	28 (39)	29 (282)	30 (250)	25 (68)
TOTAL	38 (334)	43 (874)	36 (247)	43 (961)	42 (361)	41 (847)	43 (257)	41 (951)	46 (194)	41 (1014)	41 (757)	42 (440)

*Chi-square significant at less than or equal to .05.

Table III.4

PERCENT DISTRIBUTION OF CLIENTS WITH REDUCED PROPENSITY BY TYPE OF SERVICE RECEIVED BY PROJECT**

	ALL CASES	MDT REVIEW		ONE TO ONE COUNS.		LAY THERAPY		GROUP THERAPY		PARENTS ANONYMOUS		COUPLES/ FAMILY COUNS.		SPECIAL COUNSELING	
		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
ADAMS COUNTY	49% (n=121)	51% (n=71)	49% (n=50)	52% (n=105)	25% (n=16)	62% (n=26)	45% (n=95)	50% (n=10)	49% (n=111)	50% (n=14)	49% (n=107)	40% (n=64)	63%* (n=57)	33% (n=9)	50% (n=112)
ARLINGTON	41 (186)	46 (41)	39 (145)	42 (172)	29 (14)	30 (10)	42 (176)	40 (20)	41 (166)	--	41 (186)	39 (54)	42 (132)	33 (3)	41 (183)
BATON ROUGE	48 (96)	52 (33)	46 (36)	48 (93)	33 (3)	--	48 (95)	75 (4)	47 (92)	100 (2)	47 (94)	46 (33)	49 (63)	50 (2)	48 (94)
BAYAMON	43 (123)	43 (97)	42 (26)	44 (119)	25 (4)	--	43 (123)	78 (9)	40 (114)	100 (2)	42 (121)	42 (81)	45 (42)	44 (39)	43 (84)
ARKANSAS	56 (169)	57 (44)	56 (125)	55 (53)	57 (116)	56 (165)	50 (4)	40 (10)	57 (159)	61 (38)	55 (131)	69 (13)	55 (156)	40 (5)	57 (164)
ST. LOUIS	25 (81)	22 (69)	42 (12)	25 (68)	23 (13)	35 (20)	21 (61)	23 (70)	36 (11)	60 (5)	22 (76)	33 (21)	22 (60)	67 (3)	23 (78)
TACOMA	58 (93)	58 (24)	58 (69)	61 (79)	43 (14)	71 (24)	54 (69)	51 (35)	62 (58)	80 (5)	57 (88)	65 (34)	54 (59)	100 (4)	56 (89)
UNION COUNTY	29 (321)	25 (52)	30 (269)	30 (291)	27 (30)	44 (62)	26* (259)	40 (15)	29 (306)	--	29 (321)	18 (101)	36* (220)	43 (21)	28 (300)
TOTAL	42 (1208)	41 (439)	42 (769)	41 (993)	44 (215)	52 (317)	38* (891)	39 (173)	42 (1035)	59 (69)	41 (1339)	36 (411)	44* (497)	46 (88)	41 (1120)

*Chi-square significant at less than or equal to .05.

**Individual statistics for Los Angeles and St. Petersburg clients have not been included because of the small number of cases on which we have data, 13 and 7, respectively; information on these cases has been included in the calculations of the "total" row.

Table III.4 Continued

	FAMILY PLANNING		CRISIS INTERVENTION		PARENT EDUCATION		HOME-MAKING		CHILD SERVICES		WELFARE		BABYSITTING/ TRANSPORT.		OTHER	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
ADAMS COUNTY	27% (n=11)	51% (n=110)	53% (n=38)	47% (n=83)	41% (n=17)	50% (n=104)	50% (n=6)	49% (n=115)	56% (n=43)	45% (n=78)	58% (n=40)	44% (n=81)	44% (n=16)	50% (n=105)	53% (n=42)	52% (n=79)
ARLINGTON	100 (2)	40 (184)	45 (38)	40 (148)	67 (3)	40 (183)	80 (5)	40 (181)	58 (33)	37 (153)	40 (25)	41 (161)	41 (46)	41 (140)	64 (28)	37* (158)
BATON ROUGE	33 (3)	48 (93)	49 (39)	47 (57)	50 (2)	48 (94)	44 (18)	49 (78)	38 (24)	51 (72)	52 (21)	47 (75)	39 (26)	51 (70)	46 (44)	50 (52)
BAYAMON	56 (16)	41 (107)	42 (43)	44 (80)	82 (11)	39* (112)	50 (2)	43 (121)	75 (4)	42 (119)	50 (4)	43 (119)	50 (10)	43 (113)	44 (41)	43 (82)
ARKANSAS	100 (2)	56 (167)	42 (53)	63* (116)	63 (8)	56 (161)	50 (2)	56 (167)	42 (31)	59 (138)	54 (57)	57 (112)	52 (62)	59 (107)	57 (42)	56 (127)
ST. LOUIS	--	25 (81)	18 (40)	32 (41)	16 (25)	29 (56)	--	25 (81)	40 (5)	24 (76)	31 (16)	23 (65)	24 (68)	31 (13)	33 (3)	24 (78)
TACOMA	--	58 (93)	69 (29)	53 (64)	62 (60)	52 (33)	100 (4)	56 (89)	57 (7)	58 (86)	56 (41)	60 (52)	67 (45)	50 (48)	64 (42)	53 (51)
UNION COUNTY	42 (24)	28 (297)	28 (134)	30 (187)	31 (13)	29 (308)	17 (24)	30 (297)	38 (72)	27 (249)	32 (125)	28 (196)	26 (73)	30 (248)	37 (76)	27 (245)
TOTAL	47 (62)	41 (1146)	39 (423)	43 (785)	49 (147)	41 (1061)	40 (62)	42 (1146)	45 (234)	41 (974)	44 (333)	41 (875)	39 (357)	43 (851)	48 (322)	39* (886)

*Chi-square significant at less than or equal to .05.

Table III.4 Continued

	LAY MODEL[a]	GROUP MODEL[b]	SOCIAL WORK MODEL[c]	OTHER
ADAMS COUNTY	56% (n=36)	29% (n=14)	54% (n=59)	25% (n=12)
ARLINGTON	30 (10)	41 (22)	43 (143)	18 (11)
BATON ROUGE	67 (3)	67 (6)	46 (84)	33 (3)
BAYAMON	100 (2)	78 (18)	36 (99)	25 (4)
ARKANSAS	56 (165)	--	33 (3)	100 (1)
ST. LOUIS	35 (20)	20 (54)	17 (6)	100 (1)
TACOMA	74 (27)	49 (55)	67 (9)	50 (2)
UNION COUNTY	44 (62)	15 (13)	27 (226)	20* (20)
TOTAL	53 (334)	39 (185)	38 (635)	26* (54)

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*Chi-square significant at less than or equal to .05.

[a] The Lay Model includes lay therapy counseling and/or Parents Anonymous as well as any other services.

[b] The Group Model includes group therapy and/or parent education classes as well as any other services except lay services.

[c] The Social Work Model includes individual counseling as well as any other services except lay or group services.

Table II.4 Continued

	NUMBER OF DIFFERENT SERVICES					LENGTH OF TIME IN TREATMENT		AVERAGE FREQUENCY OF CONTACT			
	1	2	3	4	5	UNDER 6 MO.	6 MO. OR MORE	ONCE A MONTH OR LESS	TWICE A MONTH	THREE OR FOUR TIMES A MONTH	WEEKLY OR MORE OFTEN
ADAMS COUNTY	70% (n=10)	50% (n=12)	35% (n=23)	45% (n=31)	53% (n=45)	38% (n=29)	52% (n=92)	40% (n=15)	60% (n=15)	39% (n=28)	52% (n=63)
ARLINGTON	39 (54)	35 (46)	46 (37)	36 (22)	52 (52)	24 (81)	54* (105)	41 (44)	44 (54)	40 (47)	37 (41)
BATON ROUGE	55 (11)	57 (21)	38 (16)	43 (14)	47 (34)	50 (48)	46 (48)	44 (18)	50 (22)	58 (24)	41 (32)
BAYAMON	40 (10)	25 (24)	59 (22)	35 (17)	48 (50)	33 (33)	47 (90)	29 (34)	41 (27)	50 (42)	55 (20)
ARKANSAS	53 (34)	68 (34)	55 (29)	56 (25)	51 (47)	41 (92)	74* (77)	78 (9)	77 (13)	71 (24)	50* (123)
ST. LOUIS	50 (2)	20 (5)	50 (10)	18 (11)	21 (53)	24 (25)	25 (56)	--	29 (14)	12 (17)	30 (47)
TACOMA	40 (5)	67 (9)	29 (14)	57 (14)	67 (51)	52 (27)	61 (66)	44 (9)	31 (13)	56 (16)	67 (55)
UNION COUNTY	27 (60)	34 (71)	15 (41)	33 (48)	32 (101)	22 (121)	34* (200)	25 (88)	30 (56)	22 (58)	35 (119)
TOTAL	40 (187)	42 (224)	39 (194)	40 (184)	43 (419)	33 (458)	47* (750)	34 (221)	42 (214)	41 (256)	45 (517)

* Chi-square significant at less than or equal to .05.

Reduction in propensity for future abuse or neglect by the end of treatment is a summary measure of outcome. It is a proxy for or an indicator of a variety of changes perceived in clients' attitudes, situations and behaviors that makes it appear to the clinician unlikely that the client will again maltreat his or her child. With the data set, it is possible to look not only at the relationships between service receipt and reduced propensity, but also at the relationships between service receipt and improvement in a number of specific areas of client functioning theorized to be related to the potential for maltreatment. Improvement on select indicators of client functioning and service receipt is displayed on Table III.5. The following is seen:

General Health. Whereas 13% of all cases in the data set exhibited improved general health during treatment, a significantly greater percent of those clients receiving specialized (alcohol, drug) counseling (26%) were reported with improved health, as did between 15% and 17% of those receiving MDT review, lay therapy, crisis intervention and child services.

Stress from Living Situation. Twenty-eight percent of all clients were said to have reduced stress from their living situations. No significant, positive relationships were seen with service receipt; however, those receiving family counseling, crisis intervention or parent education classes were less likely to improve in this area. The lay and social work service models were, however, significantly related to reduction in household stress.

Sense of Child as Person. Close to 38% of the clients receiving Parents Anonymous or parent education classes changed their attitudes toward their children from extensions of themselves to separate persons, as compared with 22% of all cases. Clients receiving lay therapy (27%) and group therapy (29%) also were more likely to improve on this measure than other clients included in the data set. The lay and group models have a significant, positive relationship with this improvement.

Table III.5

Percent Distribution of clients Receiving Select Services and Improvement on each of the Individual Functioning Indicators

	ALL CASES	MDT REVIEW		ONE TO ONE COUNS.		LAY THERAPY COUNS.		GROUP THERAPY		PARENTS ANONYMOUS		COUPLES/FAMILY COUNS.	
		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
GENERAL HEALTH	13% (n=1614)	15% (n=571)	11% (n=1043)	13% (n=1342)	10% (n=272)	16% (n=376)	12%* (n=1238)	13% (n=202)	13% (n=1412)	10% (n=90)	13% (n=1524)	12% (n=554)	13% (n=1060)
STRESS FROM LIVING SITUATION	28 (1615)	27 (568)	29 (1047)	29 (1341)	24 (274)	31 (375)	27 (1240)	27 (203)	29 (1412)	37 (90)	29 (1525)	23 (555)	31* (1060)
SENSE OF CHILD AS PERSON	22 (1609)	24 (568)	21 (1041)	21 (1337)	25 (272)	27 (373)	20* (1236)	29 (201)	21 (1408)	37 (90)	21* (1519)	22 (552)	22 (1057)
BEHAVIOR TOWARD CHILD	28 (1611)	31 (568)	26 (1043)	28 (1339)	28 (272)	35 (371)	26* (1240)	30 (201)	28 (1410)	43 (86)	27* (1523)	29 (553)	28 (1058)
AWARENESS OF CHILD DEVELOPMENT	23 (1613)	24 (569)	22 (1044)	22 (1342)	24 (271)	29 (373)	21* (1240)	21 (202)	23 (1411)	31 (90)	22 (1523)	21 (553)	24 (1060)
ABILITY TO TALK OUT PROBLEMS	25 (1615)	28 (571)	24 (1044)	25 (1342)	27 (273)	33 (373)	23* (1242)	32 (203)	25* (1412)	37 (90)	25* (1525)	21 (555)	28* (1060)
REACTION TO CRISIS SITUATIONS	23 (1600)	22 (571)	24 (1029)	24 (1339)	22 (261)	31 (360)	21 (1240)	27 (203)	23 (1397)	44 (89)	22 (1511)	21 (555)	24 (1045)
WAY ANGER IS EXPRESSED	20 (1598)	18 (570)	21 (1028)	20 (1336)	19 (262)	28 (360)	18* (1238)	24 (203)	19 (1395)	30 (90)	19* (1508)	16 (554)	22* (1044)
SENSE OF INDEPENDENCE	18 (1610)	17 (570)	19 (1040)	19 (1337)	16 (273)	25 (374)	16* (1236)	23 (201)	18 (1409)	32 (90)	18* (1520)	17 (553)	19 (1057)
UNDERSTANDING OF SELF	19 (1614)	19 (571)	20 (1043)	18 (1341)	23 (273)	28 (374)	17 (1240)	30 (201)	18* (1413)	39 (90)	18* (1524)	18 (554)	20 (1060)
SELF ESTEEM	19 (1613)	18 (572)	19 (1041)	19 (1340)	19 (273)	28 (373)	16* (1240)	21 (203)	18 (1410)	36 (90)	18 (1523)	19 (556)	19 (1057)

*Chi-square significant at less than or equal to .05.

Table III.5 Continued

	SPECIAL COUNS.		CRISIS INTERVENTION		PARENT EDUCATION		HOME-MAKING		CHILD SERVICES		WELFARE		BABYSITTING/ TRANS.	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
GENERAL HEALTH	26% (n=102)	12%* (n=1512)	17% (n=547)	11%* (n=1067)	16% (n=180)	12% (n=1434)	14% (n=85)	13% (n=1529)	17% (n=301)	12%* (n=1313)	15% (n=434)	12% (n=1180)	14% (n=453)	12% (n=1161)
STRESS FROM LIVING SITUATION	30 (100)	28 (1515)	24 (549)	30* (1066)	22 (180)	29* (1435)	26 (85)	28 (1530)	30 (300)	28 (1315)	28 (433)	29 (1182)	29 (454)	28 (1161)
SENSE OF CHILD AS PERSON	23 (102)	22 (1507)	21 (546)	23 (1063)	37 (178)	20* (1431)	15 (85)	22 (1524)	22 (298)	22 (1311)	22 (431)	22 (1178)	26 (453)	20* (1156)
BEHAVIOR TOWARD CHILD	33 (102)	28 (1509)	27 (545)	28 (1068)	39 (175)	27* (1436)	24 (83)	28 (1528)	27 (301)	28 (1310)	26 (431)	29 (1180)	30 (1161)	27 (450)
AWARENESS OF CHILD DEVELOPMENT	24 (102)	23 (1511)	21 (547)	24 (1066)	36 (179)	21* (1434)	20 (85)	23 (1528)	23 (300)	23 (1313)	23 (433)	23 (1180)	25 (453)	22 (1160)
ABILITY TO TALK OUT PROBLEMS	26 (102)	25 (1513)	28 (549)	24 (1066)	34 (180)	24* (1435)	19 (85)	26 (1530)	28 (300)	25 (1315)	28 (433)	25 (1182)	29 (453)	24* (1162)
REACTION TO CRISIS SITUATIONS	34 (101)	23 (1499)	23 (548)	24 (1052)	29 (179)	23 (1421)	24 (85)	23 (1515)	28 (298)	22 (1302)	34 (101)	23* (1499)	25 (449)	23 (1151)
WAY ANGER IS EXPRESSED	26 (102)	19 (1496)	17 (547)	22 (1051)	29 (178)	19 (1420)	12 (85)	21 (1513)	19 (298)	20 (1300)	21 (425)	20 (1173)	23 (448)	19 (1150)
SENSE OF INDEPENDENCE	28 (102)	18* (1508)	19 (546)	18 (1064)	32 (178)	17* (1432)	15 (85)	19 (1525)	21 (298)	18 (1312)	23 (430)	17* (1180)	22 (450)	17* (1160)
UNDERSTANDING OF SELF	25 (102)	19 (1512)	18 (548)	20 (1066)	32 (180)	18* (1434)	15 (85)	19 (1529)	20 (301)	19 (1313)	19 (432)	20 (1182)	22 (452)	18 (1162)
SELF ESTEEM	28 (102)	18* (1511)	19 (549)	18 (1064)	22 (179)	18* (1434)	19 (85)	19 (1528)	22 (299)	18 (1314)	22 (431)	17 (1182)	22 (451)	17 (1162)

*Chi-squared significant at less than or equal to .05.

Table III.5 Continued

FUNCTIONING INDICATORS	SERVICE MODELS			
	LAY	GROUP	SOCIAL WORK	OTHER
GENERAL HEALTH	16% (n=401)	13% (n=219)	12% (n=910)	8% (n=84)
STRESS FROM LIVING SITUATION	31 (400)	24 (220)	29 (909)	15* (86)
SENSE OF CHILD AS PERSON	30 (398)	32 (217)	17 (909)	19* (85)
BEHAVIOR TOWARD CHILD	35 (396)	32 (217)	25 (913)	19* (85)
AWARENESS OF CHILD DEVELOPMENT	30 (398)	28 (218)	19 (912)	17* (85)
ABILITY TO TALK OUT PROBLEMS	33 (398)	32 (220)	21 (911)	15* (86)
REACTION TO CRISIS SITUATIONS	33 (385)	25 (219)	20 (911)	11* (85)
WAY ANGER IS EXPRESSED	28 (385)	24 (218)	17 (909)	7* (86)
SENSE OF INDEPENDENCE	26 (399)	26 (216)	14 (909)	7* (86)
UNDERSTANDING OF SELF	28 (399)	28 (218)	14 (911)	7* (86)
SELF ESTEEM	28 (398)	19 (219)	15 (910)	11* (86)

* Chi-square significant at less than or equal to .05.

Behavior Toward Child. With respect to behavior toward child, Parents Anonymous again appears as an effective service: 28% of all cases improved their behavior toward their children during treatment, whereas 43% of those receiving Parents Anonymous did. Parent education and lay therapy counseling also appear to be helpful services in this area, whereas services most typically provided by a protective service department--individual counseling, crisis intervention, welfare--are among those least likely to be helpful in this area. As would be predicted, the lay model, followed by the group model, are significantly and positively related to this improvement.

Awareness of Child Development. Clients receiving parent education classes were more likely to have increased their awareness of child development (36%), as were those receiving lay therapy counseling (29%). A significant, proportion of those receiving Parents Anonymous were, as well. Once again, the lay model followed by the group model are significantly and positively related to increased awareness of child development.

Ability to Talk Out Problems. Parents Anonymous appears to be the most useful of the services in improving a parent's ability to talk about his or her problems. Thirty-seven percent of those receiving this service showed improvement (compared with 25% of all cases). Clients receiving lay therapy counseling, group therapy, and parent education classes, and baby-sitting or transportation also did better than other cases. Those receiving couples or family counseling did less well. Lay and group treatment packages are more highly related to this improvement than the social work model.

Reactions to Crisis Situations. By a substantial proportion (44% as compared with 23%) clients receiving Parents Anonymous were reported with improved abilities to handle crisis situations. A significantly higher proportion of those receiving lay therapy, group therapy and specialized counseling also improved. Here the lay model is clearly the most useful strategy.

Way Anger is Expressed. Once again, Parents Anonymous appears to be the treatment of choice for helping clients improve the ways in which they channel their anger. Thirty percent of clients receiving this service showed improvement in the way anger is expressed as compared with 20% of all clients. Clients receiving lay therapy counseling also were more likely to improve than other cases, whereas couples or family counseling had a significant but negative relationship with improvement in this behavior. Again, of the service packages, the lay model appears to be the most helpful in improving expression of anger.

Sense of Independence. Parent education classes and Parents Anonymous were services mostly highly and significantly associated with increased sense of independence as well. Thirty-two percent of clients receiving either of these services improved as compared with 18% of all cases. Twenty-eight percent of those receiving specialized counseling improved in this area as did 25% of those with lay therapy and comparable percents of those receiving babysitting or transportation and welfare assistance. Both the lay and group models have significant, positive relationships here.

Understanding of Self. Parents Anonymous is also the service associated with most frequent improvement in one's self understanding. We see that 38% of the clients receiving this service improved as compared with 19% of all clients. Also significant are lay therapy, group therapy and parent education classes as well as the lay and group service packages.

Self-Esteem. Finally, 19% of all clients exhibited improved self-esteem from the clinicians' perspective, as did those receiving more typical protective services, whereas 36% of clients receiving Parents Anonymous exhibited improved self-esteem, as did significant but smaller percents of those receiving lay therapy, specialized counseling, transportation or babysitting and parent education. The lay model is the service model most highly associated with this outcome.

It is clear that clients receiving Parents Anonymous, lay therapy, group therapy and parent education do quite well with respect to improvement on most select aspects of functioning, as do clients receiving the lay, and in some instances the group, treatment model. This may be explained in part by the type of client who receives this service and by the characteristics of those projects which more frequently offered these services.

In conclusion, Parents Anonymous, lay therapy, group therapy, and parent education classes appear as services associated with improvements in select aspects of client functioning as do the lay and group treatment models. Of all these services and service models, Parents Anonymous appears almost consistently to have a stronger effect.

In order to better understand the relationships between service receipt and the summary outcome measure, reduced propensity for maltreatment, multivariate analysis were used. Such analysis allows one to both assess the combined effects of service receipt and the relative effect of each service when the others are controlled for. It was found that lay therapy and parent education classes have the only significant effects with regard to reduced propensity. When studying the service model packages as a group and the summary outcome measure it was found that the lay model has the single greatest effect on reducing propensity. Group services have a comparable effect to the social work model.

Having determined the relative effects of each of the discrete services and service models, it becomes interesting to determine whether any service increases in effectiveness when offered in combination with other services. Thus, a service may be a necessary auxilliary service before some other service can become effective. Or, a service may require some other service as a precondition or complement for being effective. Thus, it might be true that individual counseling and the social work model can only be effective when the project is also providing the parent with day care to alleviate some of the pressures in the household, or with transportation help and babysitting so that the parent can attend sessions with counselors (or groups). To test the existence of mix effects, we drew upon theory to specify the most likely mix effects and then created interaction variables designating when clients received both of two or more types of services. A range of mix effects were tested:

- the social work model complemented by services to children (e.g.,day care, play therapy);

- the social work model complemented by multidisciplinary team reviews of the case. This interaction term measures whether team reviews improve the specification of services and the understanding of the case and the appropriate treatment strategy which the clinician brings to counseling;

- the number of different services received, as a general catch-all variable for multiple services. The logic of this variable is that the more services a client receives, the more comprehensive the treatment process, and the more likely that any particular service will be increased in effectiveness.

When these mix effects are included with other service predictors in multivariate analysis (notably multiple regression), they emerge either as non-significant and with small, often negative, effects. Many different forms of interaction variables were tested, but no strong interaction or mix effects emerged. Much more important are the basic service models employed -- lay, group and social work.

When the amount of discrete service provision was considered to determine whether it was necessary to get a certain amount of a service or to receive it at some regular frequency before a service would become effective, it was found that with the exception of individual counseling -- for which more frequent receipt was more strongly related to outcome -- frequency was not predictive of outcome.

(c) Combined relationships of client characteristics and service variables with reduction in propensity for future abuse and neglect: In order to begin to understand the combined effects of client characteristics and service variables on the reduced propensity for abuse and neglect, a series of multivariate analyses were performed. Such analyses begin to suggest the complex relationships between variables; they are, however, by no means conclusive. First, seriousness of assault was controlled for in the multivariate analyses with the service models. The relative effect of the service models remained unchanged. When many of the select service provision and client descriptor variables are considered as a group, absence of substance abuse is the only client descriptor which appears to be significant and its effect is small. In addition to lenghty of time in treatment and frequency of contact, receipt of the following have a significant, positive effect: the lay service model, specialized counseling and individual counseling.

As an additional check on the relative effect of select independent variables, multivariate analyses were performed using all those independent variables already found to have a significant effect on propensity. As a group, while these variables account for a small percent of the variance in propensity, they all have significant effects on propensity. Receipt of the lay service model has the strongest effect, following by having been in treatment for six months or longer.

(d) Relationships between client descriptors, service variables, select case handling descriptors, and reduced propensity: it is important to understand the extent to which case handling or management practices are related to and are thus predictive of treatment outcome. All of those case management practices found to be related to the overall quality ratings,[1] and others of substantive interest, are studied independently in terms of their relationships to reduced propensity before being considered along with service variables.

The overall summary score of the assessment of the quality of case management was not found to be related to reduced propensity. Approximately the same percent of those cases judged to have lower quality case management had reduced propensity as did those with higher quality ratings. This suggests that for this data set the overall measure of quality is not predictive of client improvement in treatment. While a few elements of case management practice may be (and, in fact, are) related to client outcome, the overall rating is not. It captures many aspects of what is considered "good practice" that have little to do with eventual client outcome and may have more to do with overall project efficiency or worker performance.

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[1] See Section II.

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For example, a strong predictor of the quality of case management is the amount of time that elapses between receipt of a referral and first contact with a client. A quick response time (within the same day for serious cases, within 2-3 days for other cases) is considered essential to ensure that a child receives any needed protection and that family crises can be alleviated. However, cases that were contacted within three days after the initial report were just as likely, in this data set, to have reduced propensity by the end of treatment as cases not seen for days or weeks after the initial referral. It is hypothesized that any negative effects of this slow early response were alleviated over the course of treatment either by other case handling factors or the nature of service receipt itself.

Two other examples of aspects of case management directly related to overall quality assessments but not directly related to client outcome help illuminate this point. First, the number of years of experience a case manager has had in the child abuse field is not related to reduced propensity. Although years of experience in the field may result in the ability to more effectively and planfully manage cases, such experience does not necessarily result in more effective workers as far as client outcome goes. Treatment outcome is influenced by the type of services a client receives and many other factors -- such as length of time in treatment -- which are not necessarily a function of years of experience in the field.

Second, quality assessors regard as important whether or not a case manager contacts the reporting source to elicit information already known about a case. Such a contact reduces duplication and maximizes the efficiency of the intake process. It is thus seen as an important aspect of quality case management. However, the proportion of clients with reduced propensity is essentially the same by the end of treatment whether or not such a contact occurs, indicating that while an important ingredient of case management, it is not an important ingredient of client outcome.

When bivariate analysis techniques are used with the discrete case handling and case management characteristics studied, the one found to have the most significant relationship with reduced propensity was caseload size. The smaller the caseload size, the more likely a client is to improve. In fact, case managers with caseloads of 1-4 were almost twice as successful as managers with caseloads of 25 or more.

When salient case handling practices are studied jointly with service variables in relation to reduced propensity, their effect continues to appear to be insignificant. In multivariate analyses, it appears that certain treatment mixes -- notably the lay service model -- remains the most effective variable in explaining outcome. This is to say that when clients receive the lay service model, irrespective of most of the case handling or management techniques used, they are more likely to improve while in treatment. The length of time in treatment (over six months) and the amount of time a clinician takes to develop a treatment plan (at least three contacts with the client) do have a small effect, irrespective of the service model offered.

(e) Relationships between client descriptors, service descriptors and reduced propensity for different types of maltreaters: Having looked at those client and service descriptor variables which appear to have significant effects on the reduction of propensity, individual groups of clients are studied separately, with respect to type of maltreatment committed, to see if the independent variables remain important in explaining outcome for particular groups of clients. This is a particularly necessary step given the higher proportion of physical abuse cases in the study population than is typically found in protective service agencies.

(1) Potential Abusers and Neglectors. Using most of the select service provision and client characteristic variables in a multivariate analysis, only two variables -- receipt of the lay service model and having preschool children -- appear as statistically significant (stable) in terms of their effect.

(2) Emotional Maltreaters. When most of the select service provision and client characteristic variables are included in an analysis of just those clients who emotionally maltreated their children, the only variable which is found to have a significant effect is the lay services model.

(3) Physical Abusers. Only cases in which physical abuse occurred are studied to determine the effects of select client and service descriptors on reduced propensity for this population. In this analysis, the following have significant, but small, effects: length of time in treatment, frequency of contact, lack of receipt of couples or family counseling, and absence of family conflict. The lay, and particularly the group, models show stronger but not stable effects relative to the social work model. These remain significant variables when controlling for the severity of the family situation. For this particular group of maltreaters, it appears that variables describing the nature of service provision (e.g., length of time in treatment) are more important in terms of outcome than the actual types of services provided.

(4) Physical Neglectors. When using most of the select service provision and client descriptor variables for just those cases classified as physical neglectors, the variables with a significant effect include: receipt of the lay service model, length of time in treatment, lack of receipt of the social work service model with children's services, and frequency of receipt of individual counseling.

(f) Summary of treatment findings: Keeping in mind that the findings from this study are suggestive, not conclusive, and not necessarily generalizable to the field, it was learned that relative to any other discrete services or combinations of services, the receipt of lay services -- lay therapy counseling and Parents Anonymous -- as part of a treatment package, appear to be more likely to result in positive treatment outcome. In all cases where these lay services were found to be effective, lay persons were provided with intensive on-the-job training and were provided with professional back-up and supervision. Group services (group therapy, parent education classes) as supplemental services also appear to have a notable positive effect, particularly for the physical abuser. Moreover, these services are relatively equally effective with serious and nonserious cases, and as or more effective with serious cases than other more traditionally oriented services where professionals have intensive one-on-one interactions with clients or seek to provide a wide array of auxillary services directed toward various client needs without the supplement of lay or group services. Auxillary services do seem to help increase the effectiveness of lay and group services, however. At the same time, severe reincidence while in treatment is more common with lay services, indicating that there may be a tradeoff between short-run protection of the child and ultimate treatment outcome. Perhaps there are techniques (e.g., careful supervision and review of cases by professionals working with lay workers) which could reduce such reincidence, but this study did not analyze this possibility directly. Also, regardless of the type of service strategy being pursued, this study suggests that the provision of a service for at least six months helps to ensure a positive outcome. These various findings appear to hold irrespective of many client descriptors theorized to influence treatment impact.

The treatment outcome findings bring into question the relevance or appropriateness of the traditional protective services treatment model (based on provision of services by professionals and the individual counseling approach, without the added use of group services or nonprofessionally delivered services) and thus challenge many of the principles used to date in the formulation of our child protection systems; however, they are really not unexpected. Proponents of self-help treatment groups (Alcoholics Anonymous, Families United, the centers for independent living being created by the severely disabled, and most notably, Parents Anonymous) and of volunteer-based groups in general have long advocated these approaches. They have argued that individuals who actively participate in reducing or at least understanding the stresses in their lives thrive from such participation. Having people "do for you" simply does not help as much as "doing for yourself." Working through problems with others struggling with the same dilemmas helps immeasurably. In addition, they have argued that lay persons (with, of course, sufficient professional backup and supervision) need not be as burdened in their work as are our protective service workers today. Their caseloads can consist of one or two families -- compared to the 15 to 25 that must, for cost reasons, be carried by the professional. Not only does this imply that the lay person (e.g., the person with a small caseload) has more time available for each client, but very likely more energy. In many ways, the argument for lay services has, thus, to do with availability and not with the fact that one lacks a degree or certain credentials. However, some have argued that the lay person is not as tightly bound to particular theoretical approaches as a professional in delivering services and that this allows for more flexibility in helping clients work through their problems.

Despite the fact that the self-help and lay concepts are widely supported, none of the studies extant in the literature compare the relative effectiveness of lay versus other treatment strategies in a systematic, quantitative manner. Indeed, except for the relatively small scale evaluation of the Extended Family Center, previously discussed, none of the studies in the literature compare the relative effects of different interventions.[1] This current study, then, represents a pioneering effort in contrasting different approaches to treating parents with abusive and neglectful behavior. There are no comparisons that can easily be made to determine the general validity of the treatment outcome findings. The findings from this study can serve as useful benchmarks for future studies, provided that all limitations with the findings, cited earlier, are kept in mind.

(C) The Cost-Effectiveness of Alternative Service Strategies

A separate Cost Analysis Report analyzes in depth the costs of delivering various kinds of services in each of the projects, and develops generic cost estimates for types of services and service packages (or models) which communities could use in planning their child abuse/neglect intervention programs. The results are presented in Tables III.6 and III.7. In a cost-effectiveness analysis, one takes cost data and compares it with the outcomes achieved by different services. Conceivably, more expensive services may justify their cost by being more effective per dollar of cost in producing desirable outcomes than less expensive services.

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[1] The EFC evaluation sought to compare the relative effectiveness of a public protective services treatment approach and that of a small, family-oriented, therapeutic program with a strong day care component.

Table III.6

Annual Cost Per Client to Deliver Services* and Annual Volumes of Units

Service	Annual Units/Clients		Cost/Client
11. Outreach	Cases	**	
12. Intake & initial diagnosis	Intake process	over 2 months	$ 157.50
14. Court-case activities	Case activities	over 3 months	378.00
15. Crisis intervention during intake	Contacts	4	54.00
16. Multidisciplinary team case review	Reviews	2	109.50
17. Individual counseling	Contact hours	52	767.00
18. Parent aide/lay therapy counseling	Contact hours	52	377.00
19. Couples counseling	Contacts	52	884.00
20. Family Counseling	Contacts	52	1,560.00
21. Alcohol, drug & weight counseling	Person sessions	52	390.00
22. 24-Hour hotline counseling	Calls	78	585.00
23. Individual therapy	Contacts	52	1,105.00
24. Group therapy	Person sessions	52	546.00
25. Parents Anonymous	Person sessions	52	299.00
26. Parent education classes	Person sessions	20	190.00
27. Crisis intervention after intake	Contacts	26	364.00
28. Day care	Child sessions	260	2,015.00
29. Residential care	Child days	90	3,397.50
30. Child development program	Child sessions	260	5,590.00
31. Play therapy	Child sessions	104	1,222.00
32. Special child therapy	Contacts	52	2,821.00
33. Crisis nursery	Child days	14	497.00
34. Homemaking	Contacts	30	682.50
35. Medical care	Visits	**	
36. Babysitting/child care	Child hours	104	364.00
37. Transportation/waiting	Rides	104	910.00
38. Emergency funds	Number of payments	**	
39. Psychological & other testing	Person tests	2	72.50
40. Family planning counseling	Person sessions	**	
41. Follow-up	Person follow-ups	2	53.00

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*Cost per client estimates include indirect costs such as general management, staff development and training, and case management and regular review.

**Estimates not available from demonstration data.

Table III.7

PROGRAM COSTS OF FIVE ALTERNATIVE SERVICE MODELS DESIGNED TO SERVE 100 CLIENTS

BASIC SERVICES:

Intake and Initial Diagnosis
Case Management and Regular Review
Crisis Intervention After Intake
Multidisciplinary Team Case Reviews (25% of caseload)
Court Case Activities (10% of caseload)
Follow-up

	Basic Model	With Ancillary Services*
INDIVIDUAL COUNSELING MODEL: Basic Services plus Individual Counseling	$135,897	$169,560
LAY THERAPY MODEL: Basic Services plus Lay Therapy Counseling Parents Anonymous (25%)	$104,372	$138,035
GROUP TREATMENT MODEL: Basic Services plus Group Therapy (50%) Parent Education Classes Individual Counseling (25%)	$124,672	$158,335
CHILDREN'S PROGRAM: Basic Services plus Child Development Program Special Child Therapy (10%)	$646,407	$680,070
FAMILY TREATMENT PROGRAM: Children's Program plus Individual Counseling Family Counseling (50%) Group Therapy (50%)	$828,407	$862,070

*Ancillary Services include Babysitting/Child Care, Transportation/Waiting, and Psychological and Other Testing.

NOTE: The costs estimated above include indirect costs of project operations and case management. If a project anticipated providing Community Activities (including Prevention, Community Education, Professional Education, Coordination, and Legislation & Policy), the above costs would constitute approximately 75 percent of the total program costs. If the model under consideration is to be housed in a Protective Services agency, the service costs should be increased by a factor of about 10 percent.

In this study, cost-effectiveness analysis simply reinforces the recommendations which would follow from the analysis of treatment outcomes. The services which seem to be more effective also tend to be those services which are the least expensive. This holds true both for particular services and for more general service models. Thus, the study's cost analysis found low average annual costs per client for lay services (lay therapy counseling $377, Parents Anonymous $299) and for group services (group therapy $546, parent education classes $190), as compared with more traditional professional services (e.g., individual counseling $767, individual therapy $1105, couples counseling $884, family counseling $1560). The annual cost for running a community program serving 100 clients and emphasizing the lay therapy model was estimated at $138,035, in contrast to $158,335 for the group treatment model and $169,560 for the individual counselor/social work model. These comparisons assume comparable basic services (e.g., intake, case management, crisis intervention, court case follow-through, and multidisciplinary team reviews) and comparable ancillary services (e.g., child care, transportation help, psychological and other testing) for all three models. At the same time, the cost estimates for the lay therapy model assumed a heavy degree of professional supervision and coordination of the lay workers.

Tables III.8 and III.9 depict the relative cost-effectiveness of select services and, most importantly, the overall service models. The first table meshes the findings from multivariate analysis of individual service impact with our separate cost analysis. Parent aide and lay therapy counseling ($24), Parents Anonymous ($54) and parent education classes ($18) clearly emerge as more cost-effective in securing a small but significant increase in the probability of a successful family outcome from treatment than does the principal service of the social work model, individual counseling ($207). Table III.9 provides perhaps a simpler, more intuitively clear picture, by examining the costs per successful outcome using various models or combinations of services. The costs per successful outcome in a project serving 100 clients is $2590 with the Lay Model, as contrasted with $4081 with the Group Model and $4462 with the Social Work Model.

Table III.8

Cost-Effectiveness of Select Services for the "Average" Demonstration Client

Service	Marginal Increase in Probability of Reduced Propensity for Child Abuse/Neglect, if Client Receives Service[1]	Annual Cost Per Client of Delivering Service[2]	Costs of Securing a 1% Increase in Probability of Reduced Propensity by Providing Service
Individual counseling	.037	$767	$207
Parent aide/lay therapy counseling	.156	377	24
Couples counseling	−.053[a]	884	n
Family counseling	−.053[a]	1,560	n
Alcohol, weight and drug counseling	.063	585	93
Group therapy	.006	546	n
Parents Anonymous	.055	299	54
Parent education classes	.106	190	18
Crisis intervention after intake	−.040	364	n
Day care	.057[c]	2,015	353
Residential care	.057[c]	3,397	596
Crisis Nursery	.057[c]	497	87
Homemaking	−.010	682	n
Babysitting/child care	−.067[b]	364	n
Transportation/waiting	−.067[b]	910	n
Multidisciplinary team reviews	−.014	109	n

a, b, c = indicate services grouped together in analysis because of conceptual similarity and small numbers of clients receiving separate services

n = service provision was not associated with a 1% increase in the probability of reduced propensity, according to results of multivariate analysis.

[1] From Table J.13 in the Adult Client Report.

[2] From Table 3 in the Cost Report.

NOTE: Effectiveness, and thus cost-effectiveness will vary for services when given in combinations with other services and perhaps for different kinds of clients.

TABLE III.9

Cost-Effectiveness of Service Models

Service Model	Probability of Reduced Propensity for Child Abuse/Neglect if a Client Receives Services[1]	Average Costs of Serving 100 Clients with Model[2]	Average Cost Per Successful Family Outcome
Lay model	.533	$138,035	$2,590
Group model	.388	158,335	4,081
Social work model	.380	169,560	4,462

[1] Calculated from Table J.19 in the Adult Client Report.

[2] From Table 5 in Cost Report.

Remembering that these estimates are suggestive only, the lay therapy model appears as the most cost-effective of the three models. It offers the highest rate of success while also requiring the least resources. The group treatment model is more effective than the social work or individual counseling model, and is also marginally less expensive and thus, on the whole, appears to be more cost-effective than the individual counseling or social work model.

Another implication for costs is the finding that effectiveness increases the longer the case is in treatment. While we have not tried to determine the most optimal duration of treatment in terms of cost-effectiveness, it is clear that strategies which seek fast client exits from caseloads and generally maximum client throughputs are not likely to be the most cost-effective strategies in terms of achieving positive outcomes for families with limited public resources. Effective treatment of child abuse and neglect appears to require a lengthy involvement with families. Public policy and program management fares better in terms of cost-effectiveness by shifting the process of service delivery to lay services, than by exhorting professionals to work harder, increase caseloads, or move cases faster through the service process.

(D) Final Conclusions on Treatment Strategies

Our analysis does not yield definitive guidelines for how to treat particular abuse or neglect cases. No service strategy worked for all cases or worked with a high level of success (e.g., 80% plus) for particular kinds of clients. No service strategy clearly proved ineffectual; most services show some moderate degree of success with families.

However, our analysis has shown some service strategies to have consistently higher rates of success than other strategies with most clients. In particular, this study suggests that child abuse and neglect programs may well want to consider the benefits of the lay model for their particular setting. It appears as a successful solution to reducing both caseworkers' caseload burdens and case costs, while enhancing the chances of treatment success. At the same time, lay services require careful planning and careful supervision, and take time to implement. The experiences of the eleven demonstration projects in setting up such services, described and analyzed at length in our other evaluation reports, should prove useful to other programs in facilitating this process.

SECTION IV:
TREATING ABUSED AND NEGLECTED CHILDREN

The importance of providing specific therapeutic intervention for the children who have been abused and neglected has only recently received attention among professionals in the field. It had previously been assumed that problems which the children might be having were directly associated with the abuse or neglect incident(s) itself, and that once cessation of the abuse/neglect was achieved, the children's problems would resolve themselves. Thus "treatment" has historically been focused on the abuser or neglector and not the victim. It has now been documented that these children do have numerous problems, many of long standing, which are not automatically remediated because, or as soon as, the physical or emotional attacks or deprivation stop.

In order to determine more precisely the types of problems which abused and neglected children have and the progress which they are able to make toward overcoming their problems when provided therapeutic intervention(s), data were collected on 70 children receiving direct services from three of the demonstration projects: the Family Center in Adams County, the Family Care Center in Los Angeles, and the Family Resouce Center in St. Louis.

Each of the projects provided a variety of services to the children in their caseloads: child development sessions, play therapy, individual and group therapy, residential care, therapeutic day care, crisis nursery services and medical care. The Family Care Center project provided primarily residential care and play therapy to ten children at a time. Most of the children at the Family Resource Center received child development sessions and play or group therapy, while the Adams County project provided all of the above mentioned services.

Over 60% of the children receiving services were boys, and the large majority were Caucasian (67%). Although the children ranged in age from birth to twelve years old, 44% were three to five years old, while almost three-quarters were between the ages of two and seven. Most children were the victims of emotional abuse or neglect or were high risk children, although 16% of the sample had sustained a severe injury. Few of the children had special characteristics such as prematurity, mental retardation, or a serious emotional or learning disability. The typical child received services from the project for nine months, although the range was from one to twenty-nine months for the total sample.

The families of the children for whom data is available (44 of the sample of 70) were similar to other abusive/neglectful families in the eleven demonstration projects. Almost half the parents were abused themselves as children, and the same proportion of families have a teenage parent in the household. In a large proportion of cases (38%), no one in the family is employed. Close to three-quarters of the families include pre-school children, but few have more than three children. Although many of the families tend to be socially isolated, only 35% exhibited real family conflict according to the clinician keeping the parent's records. The parent(s) had been in treatment for an average of sixteen months before or during which time some legal intervention was taken in the case.

In order to assess the types of problems which the group of children had when they entered the projects, and to assess their progress while in treatment, a data collection form, to be maintained by the children's clinicians, was developed. This form required assessments to be made of the children's problems and their severity at intake, quarterly intervals, and at termination. Specific children's standardized tests of abilities were also administered at intake and termination.[1]

(A) Children's Problems at Intake

By far the most important finding about the developmental and functional delays or deficits of these children at the time they entered the projects is that, as a group, they exhibit an extremely wide range of problems; there is no single area of functioning in which they are deficient, nor any specific behaviors which stand out as universally problematic, although certain dysfunctional behavior is evident in the majority of all children (or between child and parent) of all ages. There is, in short, no composite picture of "the" abused child, but, rather, a whole series of behaviors and problems which emerged for different children.

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[1] For a detailed description of the overall methodology, including data collection instruments and analysis procedures, see Child Impact Report, Berkeley Planning Associates, December 1977.

In all areas assessed for this evaluation, numerous problems of the children were evident; the functional areas of inquiry did not cluster together, nor did patterns emerge where a child with a certain problem or problems was also likely to have another problem as a matter of course. Both individual children and the sample as a whole had numerous problems in different functioning areas, but they were not the same problems, as the following tables illustrate.

Fewer children had specific growth or physical problems than had other developmental problems (Table IV.1). When present, the problems were generally ones of erratic eating patterns (14%), hyperactivity (19%), presence of tics and twitches (13%), and excessive or prolonged crying (13%), (in a few cases, crying problems were also the complete absence of crying behavior when it would have been appropriate). The children in the Los Angeles project who were younger and more severely abused had more physical problems than the other children; there were a significant number of "severe" (in contrast to "mild") problems in all areas.

Many more children exhibited problems around acquisition of socialization skills. Over 50% of the sample had either mild or severe problems in most of their interactions with peers and adults (70% of the children did not relate well with their peers), their reaction to frustration, their development of a healthy sense of self, their ability to give and receive affection, their attention span, and around issues of their general happiness (Table IV.2). The prevalence of other socialization problems among these children ranged from 11.5% of the sample to over 60%.

Family interaction patterns were also problematic for many of these children and their parents, particularly at the Adams County and Los Angeles projects, as shown in Table IV.3. At these projects, over 50% of the family interaction patterns were marred by the parent's inappropriate perception of the child's needs and parent's response to those needs, a weak parent-child bond, and problems due to the child being different from the parent's expectation. Over 40% of all the children in the sample also exhibited problems responding to

TABLE IV.1 : PROPORTION OF CHILDREN WITH PHYSICAL PROBLEMS AT INTAKE, BY PROJECT

Problem	Adams County	Los Angeles	St. Louis	Total Sample[1]		
				Mild	Severe	Total
Height	0	44.4% (4)	2.3% (1)	1.4% (1)	5.7% (4)	7.1% (5)
Weight	5.9% (1)	55.6 (5)	2.3 (1)	2.9 (2)	7.1 (5)	10.0 (7)
Head Circumference	5.9 (1)	33.3 (3)	--	--	5.7 (4)	5.7 (4)
Physical Defects	--	22.2 (2)	2.3 (1)	2.9 (2)	1.4 (1)	4.3 (3)
Sleeping Patterns	11.8 (2)	22.2 (2)	2.3 (1)	7.1 (5)	--	7.1 (5)
Eating Patterns	11.8 (2)	55.6 (5)	6.8 (3)	12.9 (9)	1.4 (1)	14.3 (10)
Malnutrition	5.9 (1)	22.2 (2)	4.5 (2)	4.3 (3)	2.9 (2)	7.1 (5)
Crying	17.6 (3)	33.3 (3)	6.8 (3)	12.9 (9)	--	12.9 (9)
Pain Agnosia	5.9 (1)	--	2.3 (1)	2.9 (2)	--	2.9 (2)
Pain Dependent Behavior	--	--	11.4 (5)	5.7 (4)	1.4 (1)	7.1 (5)
Psychosomatic Illness	17.6 (3)	--	2.3 (1)	2.9 (2)	2.9 (2)	5.7 (4)
Hyperactive	23.5 (4)	11.1 (1)	18.2 (8)	11.4 (8)	7.1 (5)	18.6 (13)
Tics/Twitches	11.8 (2)	22.2 (2)	11.4 (5)	10.0 (7)	2.9 (2)	12.9 (9)
Bites Nails	5.9 (1)	--	4.5 (2)	2.9 (2)	1.4 (1)	4.3 (3)
Poor Recuperation Following Physical Illness	--	--	4.5 (2)	1.4 (1)	1.4 (1)	2.9 (2)
	N = 17	N = 9	N = 44	N = 70		

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[1] Determinations of problem severity were calculated only for the total sample due to the small number of cases at individual projects.

TABLE IV.2 : PROPORTION OF CHILDREN WITH SOCIALIZATION PROBLEMS AT INTAKE, BY PROJECT

SOCIALIZATION PROBLEMS				Total Sample		
	Adams County	Los Angeles	St. Louis	Mild	Severe	Total
Aggression	58.8% (10)	11.1% (1)	47.7% (21)	29.17% (19)	18.67% (13)	45.7% (32)
Apathy	41.2 (7)	55.6 (5)	40.9 (18)	32.9 (23)	10.0 (17)	42.9 (30)
Affection	47.1 (8)	77.8 (7)	47.7 (21)	42.9 (30)	8.6 (6)	51.5 (36)
General Happiness	58.8 (10)	66.7 (6)	43.2 (19)	35.7 (25)	14.3 (10)	50.0 (35)
Hypermonitoring	41.2 (7)	0	27.2 (12)	20.0 (14)	7.1 (5)	27.1 (19)
Attention Span	64.7 (11)	22.2 (2)	50.0 (22)	28.6 (20)	21.4 (15)	50.0 (35)
Accident Proneness	17.6 (3)	0	11.4 (5)	8.6 (6)	2.9 (2)	11.5 (8)
Ability to Protect Oneself	35.3 (6)	33.3 (3)	20.4 (9)	21.4 (15)	4.3 (3)	25.7 (18)
Sense of Self	82.4 (14)	66.7 (6)	40.9 (18)	42.9 (30)	11.4 (8)	54.3 (38)
Attachment/Detachment	82.4 (14)	88.9 (8)	25.0 (11)	31.4 (22)	15.7 (11)	47.1 (33)
Reaction to Frustration	82.4 (14)	77.8 (7)	50.0 (22)	44.3 (31)	17.1 (12)	61.4 (43)
Reaction to Change	47.1 (8)	66.7 (6)	36.4 (16)	32.9 (23)	10.0 (7)	42.9 (30)
General Interaction with Adults	76.5 (13)	44.4 (4)	52.3 (23)	40.0 (28)	17.1 (12)	57.1 (40)
General Interaction with Peers	88.2 (15)	44.4 (4)	68.2 (30)	54.3 (38)	15.7 (11)	70.0 (49)
	N = 17	N = 9	N = 44	N = 44		

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[1] Determinations of problem severity were calculated only for the total sample due to the small number of cases at individual projects.

TABLE IV.3: PROPORTION OF CHILDREN WITH FAMILY INTERACTION PROBLEMS AT INTAKE, BY PROJECT

PROBLEM AREA	Adams County	Los Angeles	St. Louis	Total Sample		
				Mild	Severe	Total
Weak Child/Parent Bond	76.5% (13)	77.8% (7)	22.7% (10)	22.9% (16)	20.0% (14)	42.9% (30)
Fearfulness Toward Parent	47.1 (8)	22.2 (2)	13.6 (6)	15.7 (11)	7.1 (5)	22.8 (16)
Responsiveness Toward Parent	70.6 (12)	33.3 (3)	38.6 (17)	25.7 (18)	20.0 (14)	45.7 (32)
Parent's Perception of Child's Needs	100.0 (17)	100.0 (9)	50.0 (22)	38.6 (27)	30.0 (21)	68.6 (48)
Parent's Response to Child's Needs	94.1 (16)	100.0 (9)	47.7 (21)	35.7 (25)	30.0 (21)	65.7 (46)
Child's Ability to Share Feelings	88.2 (15)	44.4 (4)	31.8 (14)	29.1 (19)	20.0 (14)	47.1 (33)
Provocative Behavior	70.6 (12)	11.1 (1)	45.5 (20)	31.4 (22)	15.7 (11)	47.1 (33)
Role Reversal	47.1 (8)	---	13.6 (6)	11.4 (8)	8.6 (6)	20.0 (14)
Differences from Parents' Expectations	88.2 (15)	55.6 (5)	50.0 (22)	38.6 (29)	21.4 (15)	60.0 (42)
Harsh Discipline	70.6 (12)	44.4 (4)	27.3 (12)	24.3 (17)	15.7 (11)	40.0 (28)
	N = 17	N = 39	N = 44	N = 70		

his/her parent, sharing their feelings with others, or developing behaviors which were not provocative. Only 20% of the children showed any form of role reversal, a commonly referred-to behavior of abused/neglected children.

The children's cognitive/language and motor skill problems at intake appear widespread, but not always severe according to the results of several standardized tests administered to the children at, or shortly after, they entered the projects. On the standardized tests with IQ scores, the group was generally scoring at or one standard deviation below the mean indicating generally poor functioning, but not seriously delayed. When subtest scores were calculable, they were all relatively depressed; no one area was significantly more deficient than others, although verbal and language delays, often thought to be particular problems for these children, showed the lowest mean scores. The very young children in the Los Angeles project, in contrast to the older children at the other projects, appeared to be well within normal limits in terms of their mental development. They were, however, severely delayed with respect to psychomotor activities, scoring, on average, almost two standard deviations below the mean in psychomotor ability on the Bayley Scales of Infant Development.

These findings, again, point to the existence of varied, but pervasive problems for children who have been abused and neglected, not only in the more developmentally-based areas of cognitive, language, and motor skills abilities, but also in the more behaviorally-related areas of their abilities to interact with their parents and their socialization skills. The problems are numerous; many are of a mild type, but quite a few are of a more severe type which seriously jeopardize their ability to function adequately in future years.

(B) Progress During Treatment

The following tables illustrate the areas in which the children made progress toward overcoming their problems while receiving services from the projects.

Over half the children with physical problems at intake improved on two-thirds of the problem areas assessed, with major improvements being noted for a majority of the children in areas of height and head circumference deficits and problems with malnutrition and eating patterns as shown in Table IV.4.

Analysis of gains made toward overcoming problems in both socialization skill development and family interaction patterns showed an even greater proportion of the children making moderate or major improvement in almost all behaviors assessed as shown in Tables IV.5 and IV.6. Over half of the children with socialization problems at intake improved relative to their original behavior in 14 of the 15 areas looked at, and over 70% of the children who were apathetic, could not give or receive affection, were hypervigilant, or could not protect themselves made advances in these problem areas during treatment. And, finally, over 50% of the children had improved interaction with family members in half of the measures used to assess this problem area. The most significant increases were related to the child's ability to share his/her feelings and a reduction in the parent's use of harsh discipline as a matter of course.

There were, as has been shown, some children whose problems became worse while they were in treatment, but the proportions were generally under 25% and all of these but one were in areas of physical growth and development.

There were also a number of children (larger than the number of children who regressed) whose status for a variety of problems did not change while in treatment. Many of these problems, again, were physical problems, including the presence of physical defects, hyperactivity and the presence of tics or twitches, but some were in patterns of family interactions such as the parent's perceptions of the child's needs and subsequent response to those needs, presence of a weak parent/child bond and provocative or role/reversal behavior on the part of the child.

Some gains were also made by the children in terms of enhanced cognitive, language and motor skills as measured by standardized tests. The mean score increases on the tests from intake to termination were, in many cases, large enough to move the children from borderline categories into categories of "normal" functioning for their age group. On the McCarthy Scales of Children's Abilities some significant gains were made as shown in Table IV.7.
Other test score changes such as those on the Peabody Picture Vocabulary Test, the Vineland Scale of Social Maturity, the Bayley Scales of Infant Development

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Table IV.4

FREQUENCY DISTRIBUTION OF CHILDREN'S CHANGE IN PHYSICAL PROBLEMS FROM INTAKE TO TERMINATION FOR ALL CASES

Physical Problem	Regressed	No Change	Moderate Improvement	Major Improvement
Height	16.6% (1)		16.6% (1)	66.6% (4)
Weight	12.5 (1)	25.0 (2)	25.0 (2)	37.5 (3)
Head Circumference	--	25.0 (1)	--	75.0 (3)
Physical Defects	25.0 (1)	50.0 (2)	--	25.0 (1)
Sleeping Patterns	37.5 (3)	25.0 (2)	--	37.5 (3)
Eating Patterns	28.6 (4)	7.1 (1)	--	64.2 (9)
Malnutrition	--	--	--	100.0 (5)
Crying	27.3 (3)	27.3 (3)	--	45.4 (5)
Pain Agnosia	33.3 (1)	33.3 (1)	--	33.3 (1)
Pain Dependent Behavior	37.5 (3)	12.5 (1)	--	50.0 (4)
Psychosomatic Disorders	20.0 (1)	20.0 (1)	40.0 (2)	20.0 (1)
Hyperactive	7.7 (1)	38.5 (5)	15.4 (2)	38.5 (5)
Tics, Twitches	--	44.4 (4)	11.1 (1)	44.4 (4)
Bites Nails	--	33.3 (1)	33.3 (1)	33.3 (1)
Poor Recuperation Following Physical Illness	66.6 (4)	--	--	33.3 (2)
	Total N = 70			

Table IV.5

FREQUENCY DISTRIBUTION OF CHILDREN'S CHANGE IN SOCIALIZATION SKILLS PROBLEMS FROM INTAKE TO TERMINATION FOR ALL CASES

Socialization Problems	Regressed	No Change	Moderate Improvement	Major Improvement
Aggression	11.1% (4)	30.5% (11)	25.0% (9)	33.3% (12)
Apathy	9.1 (3)	15.2 (5)	12.1 (4)	63.6 (21)
Affection	5.3 (2)	15.8 (6)	2.6 (1)	76.3 (29)
General Happiness	12.8 (5)	20.5 (8)	10.3 (4)	56.4 (22)
Hypermonitoring	0	15.8 (3)	10.5 (2)	73.7 (14)
Attention Span	5.5 (2)	36.1 (13)	16.6 (6)	41.6 (15)
Accident Proneness	27.3 (3)	36.4 (4)	9.1 (1)	27.3 (3)
Ability to Protect Oneself	15.0 (3)	15.0 (3)	0	70.0 (14)
Sense of Self	11.9 (5)	31.0 (13)	9.5 (4)	47.6 (20)
Attachment/Detachment	6.5 (3)	30.4 (14)	28.2 (3)	34.8 (16)
Reaction to Frustration	4.5 (2)	45.5 (20)	15.9 (7)	34.1 (15)
Reaction to Change	16.6 (6)	30.5 (11)	11.1 (4)	41.6 (15)
General Interaction with Adults	4.9 (2)	29.3 (12)	17.1 (7)	48.8 (20)
General Interaction with Peers	3.9 (2)	37.3 (19)	7.8 (4)	51.0 (26)
TOTAL N = 70				

Table IV.6

FREQUENCY DISTRIBUTION OF CHILDREN'S CHANGE IN PROBLEMS IN INTERACTING WITH FAMILY MEMBERS FROM INTAKE TO TERMINATION FOR ALL CASES

Interaction Problem	Regressed	No Change	Moderate Improvement	Major Improvement
Weak Child/Parent Bond	12.5% (4)	37.5% (12)	18.8% (6)	31.3% (10)
Fearfulness Toward Parent	21.1 (4)	26.3 (5)	15.8 (3)	36.8 (7)
Responsiveness Toward Parent	14.7 (5)	38.2 (13)	17.6 (6)	29.4 (10)
Parent's Perception of Child's Needs	4.2 (2)	54.2 (26)	14.6 (7)	27.0 (13)
Parent's Response to Child's Needs	8.5 (4)	51.1 (24)	17.0 (8)	23.4 (11)
Child's Ability to Share Feelings	8.8 (3)	35.3 (12)	11.8 (4)	44.1 (15)
Provocative Behavior	14.7 (5)	38.2 (13)	11.8 (4)	35.3 (15)
Role Reversal	12.5 (2)	37.5 (6)	6.2 (1)	43.8 (7)
Differences From Parents' Expectations	15.2 (7)	26.1 (12)	19.6 (9)	39.1 (18)
Harsh Discipline	10.3 (3)	27.6 (8)	3.5 (1)	58.6 (17)

Table IV.7

CHANGE IN McCARTHY TEST SCORES FROM INTAKE TO TERMINATION (N=13)

SUB-TEST	AVERAGE INTAKE TEST SCORE	AVERAGE TERMINATION TEST SCORE	AVERAGE CHANGE IN TEST SCORES
Verbal	39.8	41.2	1.4
Perception Performance	42.3	46.3	4.0
Quantitative	39.8	40.9	1.1
Memory	42.3	40.2	-2.1
Motor	40.3	43.0	2.7
GCI	84.6	89.0	4.4

Perceptual performance t = 2.82 sig. at .01.

GCI t = 2.73 sig. at .025.

All others not significant.

and the Denver Developmental Screening Test showed similar trends.

Several factors, including the seriousness of the case at intake, re-incidence of abuse/neglect while the child was receiving services, and the length of time in treatment were shown to be poor predictors of how much a child would improve in select problem areas, although non-serious cases have a significantly greater chance to make major improvements in physical problem resolution than do serious cases.

In much the same way that the children in this sample exhibited a wide range of different problems at intake, so they appear to have very different patterns of "improvement" while receiving treatment; some improved a great deal with most of their problems, while others seem to make little or no progress. Some made consistent gains or losses across a variety of problem areas, while others made major improvements in some areas, but regressed or stayed the same in others.

Despite the uneven progress, the sheer number and variety of problems which abused and neglected children appear to have indicates a tremendous need for the addition of specific therapeutic services for children into all programs purporting to be dealing with child abuse and neglect. In addition, there is a critical need for additional research into the effectiveness and cost-effectiveness of different types of services and mixes of services to determine which will have the most impact for specific types of children or on specific problems which the children have.

SECTION V:

ELEMENTS OF A SUCCESSFUL PROJECT: RECOMMENDATIONS

For three years the practices and experiences of eleven child abuse and neglect service projects and the communities in which they reside have been studied in detail in the context of a national evaluation. This evaluation has been the first such large-scale, long-term effort and as such constitutes an exploratory, pioneering effort. Indeed, because of the paucity of research on child abuse and neglect service delivery available at the outset of this study, as much of the study effort focused on the development and refinement of techniques for studying the processes and impacts of programs as it did on the actual analysis of findings. The study findings reflect some of the current, best judgments and knowledge about child abuse and neglect service delivery; while important guidelines for the field, the findings are not, however, conclusive.

In this section, the study findings are translated into the elements of a successfully operating child abuse and neglect service program. As such, they constitute recommendations for the planning and management of child abuse and neglect services. In developing the recommendations, we have gone beyond the analytic and quantitative findings of the study, presented in the study's many final reports, and combined them with our first-hand knowledge gleened from working closely with child abuse and neglect programs for over four years. We believe that these recommendations have use for program planners and managers; just as importantly, we believe that they have value as research hypotheses for future evaluation studies in the field.

(A) Program Organization and Management

Many aspects of how a program is managed will depend upon its size, its location and what its primary goals and objectives are. However, the experiences of the demonstration projects suggest that programs are more likely to be successful if certain conditions exist.

First, while larger communities can certainly effectively utilize the services of child abuse and neglect treatment programs housed in hospitals and private social service agencies, a program is more likely to have an easier time implementing its activities and operating effectively in a community if it is housed within (or has very strong ties with) a public protective services agency. The legitimacy and respect required for both receiving and making referrals, for working with law enforcement and the courts, for coordinating efforts with other professionals in the community are much more likely to be present if a program has a protective services base. The position of the program is additionally enhanced if the program's parent or host agency (e.g., social services) is well educated about the program's purpose and activities.

The staff of the program should reflect a variety of disciplinary perspectives, and should include lay as well as professional workers, to enhance both management and treatment effectiveness. Use of volunteers, in particular, can help enrich a program both by expanding the perspectives present on the staff and by greatly expanding its resources. Continuity in the staff is important, particularly in leadership positions. For newer programs, with turnover in administrative positions, selecting new administrators from the existing staff helps immeasurably in ensuring continuity in project activities. Just as it takes a new program about six months to become operational, it takes a program with a new director from the outside almost six months to undergo the transition. (Child abuse and neglect programs cannot afford such down time.) In addition, a division in responsibilities between the person who manages a project (the director) and the person who oversees the project's treatment program (a treatment services coordinator) is important for making sure that both overall program planning and individual case planning get the direction they need.

A new program needs a strong Advisory Board, composed of individuals who have clout in the community and who will advocate for the program. Such an Advisory Board should be actively involved in program planning for at least the first two years of a program's operation.

Of the many elements of program organization and management, the following appear most important in avoiding or reducing worker burnout (a significant problem in the child abuse field) and thus enhancing project performance:

- Organizational Structure: The organizational structure facilitates efficient and effective program management when caseload size is reasonable, allowing adequate coverage of all clients; when procedures and policies are formalized, but rule monitoring is not highly restrictive, as to curtail personal flexibility in providing client services; workers are included in decision making regarding their jobs and the program operation; and accountability procedures, i.e., paper work, are minimal and directly applicable to the workers' job and the improvement of service provision.
- Recruitment and Selection Process: The recruitment and selection practices are good when a job orientation that clearly states the job activities and expectations is provided, that specifies the worker characteristics needed to cope with these activities, and provides realistic exposure to the job and clients prior to employment; i.e., attempts to match workers' interests, personal job expectations and skills with the job demands, expectations and characteristics.
- Leadership: Leadership is such that it is neither passive nor authoritarian, but provides support and structure and conveys a sense of trust in staff.
- Communication: Communication is good in that it consists of formal channels of communication, assures that all relevant information is transmitted directly to all staff in a timely, appropriate manner; conflicts are directly handled by individual staff, or inter-staff differences are facilitated by a concerned third party in a timely fashion.
- Supervision: Supervision, which perhaps is better labeled consultation, provides monitoring of the quality of work of the individuals; gives direct feedback to workers on their performance; provides support; facilitates workers' jobs by assisting with development of resources and service delivery networks in the community; and provides advocacy on behalf of the clients and workers within the agency.

- **Job Design:** Job designs provide variety of work tasks; opportunities to develop and participate in innovative and creative treatment programs; offer job autonomy; provide a sense of accomplishment and achievement; and allow avenues of personal development and actualization. Diversity on the job, in particular, is an important tool in avoiding burnout.
- **Work Environment:** A work environment is efficient and planful in that program goals, policies, and procedures have been specified; client treatment goals have been developed and prioritized, plans to accomplish these goals are specified; case records and information systems give direct feedback on client progress and goal status; and work pressure and crisis orientation is minimized.

Child abuse and neglect programs can anticipate that approximately 40% of the program budget will be consumed by overhead operations, including staff training and development, program planning and general management. While these activities are crucial to a well-functioning program, not much more than this proportion of the budget should be spent on them, and overtime program management should seek to reduce costs in this area. In addition, a program should plan on allocating about 10% of its budget on those community-oriented activities that enhance interagency communication and coordination and result in a better trained and educated community.

(B) Treating Abusive and Neglectful Parents

Child abuse and neglect are different phenomena in many ways; the overt or covert acts associated with them, as well as the characteristics of the maltreatments differ. However, the experiences of the demonstration projects suggest that many aspects of treatment can, and perhaps should, be the same. In planning for treatment services, then, while a program should consider the generic costs of different services and service models generated from this study to identify the less costly services, a program should not be too concerned about developing different mixes of services from different types of clients. Client characteristics, and even case management practices, have less to do with treatment effectiveness than does the type of service offered.

A program that is likely to be successful with clients (and success might well mean that only half of the clients served improve, such that reincidence of abuse or neglect after termination is unlikely), would reflect the following:

- Range of Services Offered: A full range of treatment services, including therapeutic, educational, advocacy and supportive services, to meet all of a client's needs, are available to the program's clients, even though they may not all be provided directly by the program staff but on a referral basis.
- Focus of Service Model: The focus of the service model offered is on the use of lay treatment workers (lay therapists or parent aides) and the use of self-help groups (Parents Anonymous), but group services (group therapy, parent education classes) are also stressed, as is the use of individual counseling as the basis for case management.
- Service Prescription: The types of services offered do not necessarily vary by clients' characteristics but rather needs. Intense, immediate treatment intervention is available for the more serious maltreaters and 24-hour crisis intervention is available for all clients throughout treatment.
- Amount of Service Offered: Clients receive more than one or two different types of services, are in treatment for at least six months, and are seen by service providers on a weekly basis at least during the first six months of treatment.

The experiences of the demonstration projects suggest that the lay service model is not only the most effective, but also the most cost-effective (by a factor of 2). Clients who manifest certain needs (for money, for medical care, for alcohol counseling) should also receive the kinds of advocacy or supportive services designed to meet these needs. Such ancillary services include 24-hour availability for crisis intervention, not because crisis intervention directly influences outcome, but because helping clients through crisis is a precursor to helping them improve. Likewise, the use of multidisciplinary teams is important in helping workers learn how to identify client needs. Thus, while such team reviews are not directly related to positive outcome, they are important in assisting a clinician to understand how to help a client improve.

While a focus on lay services is important, it is useful to keep in mind that clients receiving lay services in the demonstration projects were more likely to be reported with severe reincidence while in treatment. This suggests a need for careful case management and supervision by professionally trained workers, particularly during the early stages of treatment. Improvement in treatment cannot be measured by reincidence in treatment. Severe reincidence may well occur, but a client may still benefit from services received. (Measurement of success comes from changes in a client's functioning over time, which can be reflected in a proxy measure of the clinician's overall assessment of reduced propensity by the end of treatment.)

In order for treatment programs to function well, communication among client and service provider, and among all service providers working with a given _family_, is essential. While it appears most important for a program to provide services to both parents and children, this is not an easy treatment approach. Parent and children's workers often have a difficult time coordinating their efforts. Parents may feel conflicted about the attention their children are getting in treatment both because of the perception that this reduces workers' focus on the parents _and_ it reduces the parents' focus on the children. Programs that seek to work with both parents and children must organize both case management and treatment services so that they positively impact on the _family_, but not at the expense of the adult or the child.

(C) Treating Abused and Neglected Children

Children who have been abused and neglected have a number of emotional, developmental and psycho-social delays or deficits as a result of (or minimally related to) the abuse or neglect sustained, and the generally deprived environments in which they are growing up. They have specific problems in numerous functional areas: physical growth and development, socialization skills and bahavior, interaction patterns with family members, and cognitive, language and motor skill development.

In order to begin to remedy these deficits in a meaningful way, child abuse and neglect programs need to make available, either directly or by contract or referral, specific therapeutic services for children in addition to services for parents. Although most existing high quality programs for children with general emotional or developmental delays would probably

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provide an adequate setting for dealing with these children's problems, some specific considerations related to the abused or neglected child's background and situation should be considered in developing therapeutic services for them. These considerations include:

- Breadth of Problems: Abused and neglected children exhibit problems in a wide range of areas, not only developmentally-related areas such as language and motor skills, but also in the more emotionally-related areas of socialization skills with adults and peers and interaction patterns with family members. Almost as many of these problems are considered to be "severe" as they are "mild". Programs must be able to provide, therefore, a variety of interventions, with different goals, in order to deal effectively with the different types of problems they are likely to encounter among the children they are serving.
- Specific Behaviors: Although the breadth of problems is wide, there are some common behavioral characteristics which are likely to influence service provision and effectiveness; these include an overly aggressive or apathetic posture, extreme anxiety and hypervigilence which are likely to depress the child's scores on standardized tests, an inability to relate to either adults or peers in any acceptable manner, and a very poor relationship with their parents which may preclude enlisting much support in the therapeutic process from the parents.
- Coordination of Parent and Child Interventions: Because many of the problems exhibited by the children are a result of their environmental situation, particularly their relationship with their parent(s), treating either the parent(s) or the child alone is unlikely to be effective. Although separate service strategies are required for each, coordination between those service providers working with the child and those working with the parent(s), such that each understands what the other is attempting to accomplish, is likely to be more effective than providing services totally independent of each other.

- Effectiveness of Services: Many of the problems these children exhibit are not able to be remediated duirng the therapeutic process. Certainly projects should not expect to have complete success with all of the abused and neglected children that they work with. Rather, projects should strive for maximum effectiveness while realizing their limitations due to the actual amount of time they will be able to work with these children and the array of environmental factors which influence the child for which they, as treatment workers, have no control. The seriousness of the case at intake, reincidence of abuse or neglect while the child is in treatment or the length of time a child is in treatment have not been shown to be good predictors of how well a child will progress while in treatment. More likely, the intensity and appropriateness of the services provided affect how a child responds while in treatment.

Providing the types of services required to help ameliorate the problems which abused and neglected children exhibit is costly and time consuming. However, it seems most apparent that child abuse and neglect treatment programs must work with these children, both because of the serious nature of the problems they sustain as a result of the abuse and neglect jeopardize their chances for a healthy childhood, and because, as a preventive measure, early treatment of these children's problems may well reduce the likelihood of their becoming a burden on society --perhaps as abusive parents-- when they grow up.

(D) Case Management

While case management practices will vary out of necessity across clients, because of the differences across clients, the experiences of the demonstration projects suggest that projects are more likely to be successful if they adhere to the following:

- Time between Report and First Client Contact: Intake workers intervene immediately if a report is considered an emergency and within a few days for all other reports to ensure adequate protection of the child and to detect family crises.
- Number of Contacts (following the first contact) prior to Decision on Treatment Plan: At least 3-5 meetings are held with a client,

after the first contact, before a treatment plan is developed to ensure that a thorough assessment of client needs is conducted.

- *Amount of Time between First Contact and Delivery of First Treatment Service*: Even though the treatment plan is not finalized, provision of treatment services begins within one week of the first contact with the client (if they do not begin during the first contact) to help alleviate immediate, pressing crises.
- *Use of Multidisciplinary Team Reviews:* Multidsiciplinary Team Reviews are used for the more serious or complex cases at intake and at some other point in the treatment process. Every case manager presents at least one of his/her cases to such a team every six months. The use of such teams can greatly enhance a worker's knowledge about how to best handle future cases, and thus is an important educational tool.
- *Use of Case Conferences (Staffings)*: Progress on every case is reviewed in a meeting of two or more workers once every three months, including at the time of termination.
- *Use of Outside Consultants*: Consultants representing different disciplines are used by case managers particularly for input on the more complex or serious cases to ensure that interdisciplinary perspectives are taken into account.
- *Responsibility for Intake*: Intakes are conducted by more experienced workers.
- *Continuity of Case Manager*: When possible, the manager of a case remains the same throughout the treatment process to avoid disruption in service delivery.
- *Communication with Other Service Providers*: Case managers maintain ongoing communication with all other service providers working with a given case to keep abreast of client progress.
- *Contacts with the Reporting Source:* The reporting source is contacted to gather available background information on the case and to discuss the client's progress, not only to reduce duplication of efforts but also to build trust and confidence between reporting agencies and child abuse/neglect programs.

- Client Participation: Clients are involved in the development of their own treatment plans and review of progress.
- Frequency of Contact between Client and Case Manager: Case managers see clients frequently enough (once a week during the early stages of treatment, once or twice a month once the case has stabilized) to assess progress and the appropriateness of the treatment plan.
- Length of Time in Treatment: Cases are in treatment for at least six months, but rarely for two years. Clients are terminated according to specified criteria, tied to client treatment goals; clients are referred to other services at termination if necessary.
- Follow-up Contacts: Follow-up contacts are conducted with every terminated case within two months from the time of termination with the explicit purpose of determining whether or not additional services are required.
- Case Records: Case records, adequately describing the client's problems, the treatment plan, the services provided and progress, are maintained on every client not only to assist treatment workers in case review but also to ensure continuity should there be turnover in treatment workers or the case manager. Workers are trained in how to maintain and use case records to assess client progress.
- Qualifications of Case Manager: Case managers, as distinct from treatment workers, have extensive training in this area.
- Caseload Size: Caseload sizes are kept small, well under 25 when possible, for professionally trained workers; fewer than four lay or part-time workers.

Of these norms or standards, compliance with the following appear in the study to be regarded as more important in terms of overall quality case management by experts in the field: short time between report and first contact with client; contacting reporting source for further background information; greater frequency of contract with the case; greater length of time in treatment; use of multidisciplinary team reviews; use of outside consultants; smaller worker caseload sizes; and use of follow-up contacts after termination. Of these factors, the two most clearly associated with client outcome by the end of treatment are greater length of time in treatment and smaller caseload sizes. While many aspects of case management are not directly tied to treatment outcome, good case management practices are important in helping to ensure clients get to the services they need, when they need them. Good case management practices also enhance project efficiency.

(E) The Community Context

It appears that child abuse and neglect service programs are more likely to be successful if they operate within the context of a community-wide child abuse and neglect system with the following characteristics:

(1) Community Coordination Mechanisms: The community has a community-wide coordinating body for child abuse and neglect, with representation from all those agencies in the community that are or should be concerned with child abuse and neglect (minimally including protective services, the juvenile court, the police and/or sheriff's department, the schools, the local hospital(s) treating children, and private service agencies). This group takes responsibility for eliminating the fragmentation, isolation, duplication and inefficiency in the community's child abuse and neglect system. Specific coordinating agreements -- formal, written -- exist between all key agencies in the community system.

(2) Interdisciplinary Input: Interdisciplinary input (including legal, medical, social service, psychological and educational) is present at all stages in the treatment process (from intake and initial diagnosis through treatment and termination). In addition to having expanded agency staff to include several different disciplines, having hired consultants to work with agency staff, and generally having staff from different agencies work together, the community has a Multidisciplinary Review Team available to review some, if not all, identified cases of abuse and neglect.

(3) Centralized Reporting System: A 24-hour reporting and response system exists in a central location, implying that reports can be made on a 24-hour basis, follow-up on reports is immediate and handled by one agency to avoid duplication.

(4) Service Availability: A full range of therapeutic, educational, advocacy and supportive services are available to both actual and potential physical and emotional abusers and neglectors and their children. The services of both lay and professional providers are utilized as are client-operated services.

(5) Quality Case Management: There is adherence to minimum standards of case management in all agencies in the system including: prompt response to all reports; planful decision-making concerning service provision with interdisciplinary input; prompt assignment of clients to the agency or service provider best able to provide necessary services; receipt by clients of the appropriate services at the required level of intensity according to their needs; referral to other service providers when necessary with follow-up to make sure the client gets there; termination of clients according to established criteria; and follow-up on all terminated clients to see if they are in need of further services.

(6) Community Education and Public Awareness: Training and education is provided on an ongoing basis to all relevant professional groups or classes of workers who are involved in the detection, treatment or legal aspects of child abuse. All key agencies in the system take responsibility to provide educational presentations on child abuse and neglect to all community and civic groups who request it and additionally seek out and provide education to those public groups needing but not requesting it.

Of those essential elements of a well-functioning child abuse and neglect system, community service programs appear, in the study, to be best able to impact on the following through a variety of community-oriented activities: increased awareness of and knowledge about child abuse and neglect on the part of professionals and the general public; increased availability of a comprehensive range of services available to abusive/neglectful families; increased centralization and coordination of the receipt of reports and the conduct on investigations; and improved management of cases.

(F) Conclusion

In conclusion, it would appear that child abuse and neglect services are maximized if:

- they are closely affiliated with or housed within public, protective service agencies;
- the program participates cooperatively with law enforcement, local schools, hospitals and private social service agencies in the community in the identification and treatment of abuse and neglect as well as the education and training of professionals and the general public;
- the program has strong, supportive leadership, a variety of disciplines on the staff, decentralized decision making, clearly specified rules but allowance for flexibility of the rules as clients' needs dictate;
- the program stresses certain aspects of case management including prompt, planful handling of cases, frequent contact with cases, small caseload sizes, coordination with other service providers and use of multidisciplinary review teams and consultant input for the more complex or serious cases;
- the program utlizes more highly trained, experienced workers as case managers, but stresses the use of lay services (lay therapy) or self-help services (Parents Anonymous) in its treatment offerings, as well as 24-hour availability;
- therapeutic treatment services are provided to the abused and neglected children in families served;
- careful supervision is available to lay workers, particularly during the first few months they are working with a case.

Even the more successful child abuse and neglect service programs should not expect to be completely effective with their clients. To successfully treat half of one's clients, so that they need not become protective service clients in the future, appears to be a norm for the field.

APPENDIX A

MILESTONES IN THE DEMONSTRATION/EVALUATION EFFORT

1973	October:	Issuance of request for proposals from communities interested in establishing a demonstration program.
1974	January:	Congress passes Child Abuse Act, Public Law 93-247, establishing National Center on Child Abuse and Neglect (NCCAN).
	April:	Issuance of request for proposals for evaluation contract.
	May:	Award of three-year evaluation contract to Berkeley Planning Associates.
	July:	Presentation of evaluation plans to OCD, SRS and HRA -- Rockville, Maryland and Colorado Springs, Colorado.
	August:	First meeting of projects, federal monitors and evaluators -- Alexandria, Virginia.
	September:	First round of site visits to projects; collection of baseline data.
	November:	Begin second round of site visits to projects.
1975	January:	NCCAN funds 20 additional three-year demonstration projects. Ten of eleven projects fully operational. Projects begin record keeping for BPA.
	February:	Workshop on strategies for assessing quality -- Berkeley, California.
	March:	Third round of site visits. Meeting with projects -- Washington, D.C.
	May:	Projects receive second year of funding.
	June:	Begin fourth round of site visits.
	July:	Quality assessment pre-test.
	September:	Six projects assigned new Project Monitor. First year or evaluation work completed.

1975	November:	Evaluation assigned new Project Officer.
	December:	Second year of evaluation work funded.
1976	January:	Begin fifth round of site visits.
		Meeting with projects -- Atlanta, Georgia.
	March:	Begin quality assessment visits.
	April:	Meeting with projects -- Berkeley, California.
	May:	Begin sixth round of site visits.
		Projects receive third year funding.
		Finalization of high priority evaluation questions.
	July:	Projects receive additional funding for third year.
	August:	Begin project management/worker burnout data collection visits.
	September:	Seventh round of site visits.
		Third year of evaluation funded.
	November:	Meeting with projects -- Annapolis, Maryland.
	December:	Begin final quality assessment visits.
		End of data collection on projects' community-related activities.
		End of adult client data collection period.
1977	January:	Begin eighth and final round of site visits.
		Final community systems data collection.
	April:	Formal end of demonstration period.
		End of process data collection.
		End of child client data collection period.
		Meeting with projects -- Houston, Texas.
	September:	Draft evaluation reports completed.
	December:	Final evaluation reports completed.

APPENDIX B

Listing of Major Evaluation Reports and Papers

Reports

(1) A Comparative Description of the Eleven Joint OCD/SRS Child Abuse and Neglect Demonstration Projects; December 1977.

(2) Historical Case Studies: Eleven Child Abuse and Neglect Projects, 1974-1977; December 1977.

(3) Cost Report; December 1977.

(4) Community Systems Impact Report; December 1977.

(5) Adult Client Impact Report; December 1977.

(6) Child Impact Report; December 1977.

(7) Quality of the Case Management Process Report; December 1977.

(8) Project Management and Worker Burnout Report; December 1977.

(9) Methodology for Evaluating Child Abuse and Neglect Service Programs; December 1977.

(10) Guide for Planning and Implementing Child Abuse and Neglect Programs; December 1977.

(11) Child Abuse and Neglect Treatment Programs: Final Report and Summary of Findings; December 1977.

Papers

"Evaluating New Modes of Treatment for Child Abusers and Neglectors: The Experience of Federally Funded Demonstration Projects in the USA," presented by Anne Cohn and Mary Kay Miller, First International Conference on Child Abuse and Neglect, Geneva, Switzerland; September 1976 (published in International Journal on Child Abuse and Neglect, Winter 1977).

"Assessing the Cost-Effectiveness of Child Abuse and Neglect Preventive Service Programs," presented by Mary Kay Miller, American Public Health Association Annual Meeting, Miami, Florida; October 1976 (written with Anne Cohn).

"Developing an Interdisciplinary System for Treatment of Abuse and Neglect: What Works and What Doesn't?", presented by Anne Cohn, Statewide Governor's Conference on Child Abuse and Neglect, Jefferson City, Missouri; March 1977 (published in conference proceedings).

"Future Planning for Child Abuse and Neglect Programs: What Have We Learned from Federal Demonstrations?", presented by Anne Cohn and Mary Kay Miller, Second Annual National Conference on Child Abuse and Neglect, Houston, Texas; April 1977.

"What Kinds of Alternative Delivery Systems Do We Need?", presented by Anne Cohn, Second Annual National Conference on Child Abuse and Neglect, Houston, Texas; April 1977.

"How Can We Avoid Burnout?", presented by Katherine Armstrong, Second Annual National Conference on Child Abuse and Neglect, Houston, Texas; April 1977.

"Evaluation Case Management", presented by Beverly DeGraaf, Second Annual National Conference on Child Abuse and Neglect, Houston, Texas; April 1977.

"Quality Assurance in Social Services: Catching up with the Medical Field", presented by Beverly DeGraaf, National Conference on Social Welfare, Chicago, Illinois; May 1977.

APPENDIX C

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National Center for Health Services Research publications of interest to the health community are available on request to NCHSR, Office of Scientific and Technical Information, 3700 East-West Highway, Room 7-44, Hyattsville, MD 20782 (telephone: 301/436-8970). Mail requests will be facilitated by enclosure of a self-adhesive self-addressed mailing label. These publications also are available for sale through the National Technical information Service (NTIS), Springfield, VA 22161 (telephone: 703/557-4650). PB and HRP numbers in parentheses are NTIS order numbers. Publications which are out of stock in NCHSR are indicated as available only from NTIS. Prices may be obtained from the NTIS order desk on request.

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(HRA) 77-3161	Changes in the Costs of Treatment of Selected Illnesses, 1951-1964-1971 (HRP 0014598)
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(HRA) 77-3152	How Lawyers Handle Medical Malpractice Cases (HRP 0014313)
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This report summarizes the findings from a three-year evaluation of 11 demonstration service projects on child abuse and neglect. Contents include: a description of the eleven projects in terms of their goals, service activities, organization and management styles, staffing patterns, resource allocations and service costs, types of clients served, methods of case management used and community activities; the factors associated with worker burnout; the essential elements of a quality case management process; the factors associated with program efficiency; the relative effectiveness of alternative service strategies for abusive and neglectful parents and the cost-effectiveness of different services; and the effects of treatment for abused and neglected children. Recommendations regarding the elements of these projects are also presented.

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Berkeley Planning Associates
Berkeley, California

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16. Abstracts

This report summarizes the finding from a three year evaluation of eleven child abuse and neglect demonstration service projects. Contents include a description of the methodology, project profiles, comparative descriptions of projects, project management aspects, as well as description of other components of the study related to the quality of case management process. Conclusion and recommendations are also outlined. The volumes are titled as follows: Evaluation of Child Abuse and Neglect Demonstration Projects 1974-1977: Volume I. Executive Summary of Final Report; ... Vol. II. Final Report; ... Vol. III. Adult Client Impact; ... Vol. IV. A Comparative Description of the Eleven Projects; ... Vol. V. Community Systems Impact; ... Vol. VI. Quality of the Case Management Process; ... Vol. VII. Cost; ... Vol. VIII. Methodology; ... Vol. IX. Project Management and Worker Burnout; ... Vol. X. A Guide for Planning and Implementing; ... Vol. XI. Child Client Impact; and ... Vol. XII. Eleven Historical Case Studies.

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EXECUTIVE SUMMARY

Introduction

In May of 1974, prior to expenditure of funds appropriated to the Child Abuse and Neglect Prevention and Treatment Act, Public Law 93-247, the Office of Child Development and Social and Rehabilitation Services of DHEW jointly funded eleven three-year child abuse and neglect service projects in order to develop and test alternative strategies for treating abusive and neglectful parents and their children and alternative models for coordination of community-wide child abuse and neglect systems. The projects, spread throughout the country and in Puerto Rico, differed by size, the types of agencies in which they were housed, the kinds of staff they employed, and the variety of services they offered. Health Resources Administration awarded a contract to Berkeley Planning Associates to conduct a three-year evaluation of the projects. The overall purpose of this evaluation was to provide guidance to the federal government and local communities on how to develop community-wide programs to deal with problems of child abuse and neglect in a systematic and coordinated fashion. The study, which combined both formative (or descriptive) and summative (or outcome/impact-related) evaluation concerns, documented the content of the different service interventions tested by the projects and determined the relative effectiveness and cost-effectiveness of these strategies. Specific questions, addressed with quantitative and qualitative data gathered through a variety of collecting techniques, notably quarterly five-day site visits, special topic site visits and information systems maintained by the projects for the evaluators, include:

- What are the problems inherent in and the possibilities for establishing and operating child abuse and neglect programs?
- What were the goals of each of the projects and how successful were they in accomplishing them?
- What are the costs of different child abuse and neglect services and the costs of different mixes of services, particularly in relation to effectiveness?
- What are the elements and standards for quality case management and what are their relationships with client outcome?
- How do project management processes and organizational structures influence project performance and, most importantly, worker burnout?

- **What are the essential elements of a well-functioning child abuse and neglect system and what kinds of project activities are most effective in influencing the development of these essential elements?**
- **What kinds of problems do abused and neglected children possess and how amenable are such problems to resolution through treatment?**
- **And, finally, what are the effectiveness and cost-effectiveness of alternative service strategies for different types of abusers and neglectors?**

This document summarizes the findings of the evaluation with respect to the above questions.

I. Methodology

The study was divided into discrete study components, each with a different methodological approach:

General Process Component. In order to determine the problems inherent in establishing and operating child abuse and neglect programs and to identify the range of management and service strategies for such programs, all aspects of the projects' operations were carefully monitored, primarily through the quarterly five-day site visits by BPA staff. During these structured site visits, interviews, group discussions, record reviews and observation techniques were used. All of the problems and possibilities encountered both in setting up and running different project components were documented. Historical Case Studies of each of the projects, detailing all their activities over the three-year demonstration period, were prepared. Analysis of common experiences across projects resulted in the development of a Handbook for Planning and Implementing Child Abuse and Neglect Programs.

Project Goals Component. For purposes of assessing the extent to which projects accomplished their own unique set of goals, during site visits in the first year of the evaluation, using Andre Delbecq's Nominal Group Process Technique, BPA assisted each project in the clarification of its own specific and measurable goals and objectives. Project staff, administration and advisory board members participated in this reiterative process. At the end of the first year, with project input, attainment measures for each of the goals and objectives were identified, and at the end of the second and third years, BPA staff, using interviews and record reviews, assessed the extent to which projects had accomplished that which they had set out to do.

Cost Analysis Component. To determine the costs of different services, approximately one month out of every four project staff monitored their time and resource expenditures in relation to a set of discrete project activities or services on cost accounting forms developed by BPA. Donated as well as actual resources were accounted for, as were the number of units of service provided in each of the service categories. Calculations were then made for the percentage distribution of all resources to discrete activities and the unit costs of different services provided by each project in the sample months and on average for the operational phase of the project. The value of donated resources was added to unit costs to determine the total value of services provided. And, once adjustments were made for regional wage and price differences, comparisons were made across projects to determine both the average costs and the most efficient methods of delivering services.

Quality of the Case Management Process Component. In the interest of identifying standards for quality case management process and understanding the relationship between case management and client outcome, BPA consulted with a number of child abuse and medical care audit specialists to identify both the elements of and methods for assessing the quality of case management. The methodology, once pretested at four sites and refined, consisted of visits by teams of child abuse/neglect experts to the projects during their second and third years to review a random sample of case records from each of the treatment workers in a project and interview the workers about those cases reviewed. Descriptive and multivariate analyses allowed for the identification of the most salient aspects of case management and norms of case management across the projects which can serve as minimal standards for the field. By combining these data with that collected through the adult client component, the relationships between case management and client outcome were identified.

Project Management and Worker Burnout Component. In order to determine how project management processes and organizational structures influence project performance and in particular worker burnout, visits were made to each of the projects in the third year to elicit information about management processes, job design and job satisfaction, through interviews and/or questionnaires with project management and staff (including those who had left the project). A combination of both quantitative and qualitative data analysis was then carried out to define organizational and management aspects of the projects, to establish the prevalence of worker burnout among staff, and to determine the relationships between these factors.

Community Systems Component. In order to determine the extent to which the projects had an influence on their local communities in establishing a well-functioning, community-wide child abuse and neglect system, data on the functioning of the eleven communities' child abuse and neglect systems were collected. A series of interviews with personnel from the key agencies (protective services, hospitals, law enforcement, schools, courts and foster care agencies) in each community were conducted to determine the status of the community system before implementation of the project, including the services available, coordination mechanisms, knowledge of state reporting laws, resources committed to child abuse and neglect, the ways in which agencies functioned with respect to individual cases, and how agencies worked together around specific cases or general system problems. These people were re-interviewed at yearly intervals to collect information about the changes which had occurred or were occurring in each community. Each project also maintained data for this evaluation on the educational and coordination activities which project staff undertook to improve their community systems, and the nature and results of these activities. In addition to the above data, supplemental information about changes in each community system was obtained during each site visit from project personnel, project advisory board members, and knowledgeable individuals in the community. Analyses of the information gathered included comparing the essential elements of a well-functioning community-wide system with changes seen in project communities.

Children's Component. Even though very few of the projects directly provided treatment services to the abused or neglected child, because of the paucity of information on the kinds of problems abused and neglected children possess and the benefits of various treatment services for these children, clinicians at the three projects working with children maintained problem-oriented records, developed by BPA, on the children served from the time of intake through termination. The analysis, which included data gathered through the use of select standardized tests, identified the range of problems children possessed and the degree to which these problems appear to be resolvable during treatment.

Adult Client Component. Central to the entire study was the effort to determine the effectiveness and cost-effectiveness of alternative service strategies for different types of abusers and neglectors. Clinicians at the projects maintained complete records, on forms developed by BPA, on 1724 adult clients receiving treatment during 1975 and 1976, from the time of intake through termination. Data included: basic demographics, information on the nature and severity of the maltreatment, the amount and type of services received by the client, and outcome information including improvements in parents' functioning and reincidence of abuse or neglect. These data were first analyzed by project and for the whole demonstration program to determine relationships between client characteristics, services received and outcome. Then, data from other parts of the study, including case management and program management information, were included to determine the extent to which these other variables help explain outcome. Finally, data on service costs were used to determine the cost-effectiveness of alternative strategies.

Limitations. The evaluation was concerned with projects selected because of the unique or different approaches they intended to demonstrate, not because they were representative of child abuse and neglect programs across the country. The methods used were largely developed for this study, given it was the first of its kind in the field. No control groups were studied. Thus, the findings cannot be generalized to all child abuse and neglect programs, nor can they be viewed as conclusive. They are, however, suggestive of directions child abuse and neglect treatment programs might take.

II. Project Profiles

As a group, the projects demonstrated a variety of strategies for community-wide responses to the problems of abuse and neglect. The projects each provided a variety of treatment services for abusive and neglectful parents; they each used mixes of professionals and paraprofessionals in the provision of these services; they each utilized many different coordinative and educational strategies for working with their communities. While not an exhaustive set of alternatives, the rich variety within a project and across projects has provided the field with an opportunity to systematically study the relative merits of different methods for attacking the child abuse and neglect problem.

While the projects embraced similar goals, each project was also demonstrating one or two specific and unique strategies for working with abuse and neglect, as described below:

The Family Center: Adams County, Colorado. The Family Center, a protective services-based project housed in a separate dwelling, is noted for its demonstration of how to conduct intensive, thorough multidisciplinary intake and preliminary treatment of cases, which were then referred to the central Child Protective Services staff for ongoing treatment. In addition, the Center created a treatment program for children, including a crisis nursery and play therapy.

Pro-Child: Arlington, Virginia. Pro-Child demonstrated methods for enhancing the capacity and effectiveness of a county protective services agency by expanding the number of social workers on the staff and adding certain ancillary workers such as a homemaker. A team of consultants, notably including a psychiatrist and a lawyer, were hired by the project to serve on a multidisciplinary review team, as well as to provide consultation to individual workers.

The Child Protection Center: Baton Rouge, Louisiana. The Child Protection Center, a protective services-based agency, tested out a strategy for redefining protective services as a multidisciplinary concern by housing the project on hospital grounds and establishing closer formal linkages with the hospital including the half-time services of a pediatrician and immediate access of all Center cases to the medical facilities.

The Child Abuse and Neglect Demonstration Unit: Bayamon, Puerto Rico. In a region where graduate level workers are rarely employed by protective services, this project demonstrated the benefits of establishing an ongoing treatment program, under the auspices of protective services, staffed by highly trained social workers with the back-up of professional consultants to provide intensive services to the most difficult abuse and neglect cases.

The Arkansas Child Abuse and Neglect Program: Little Rock, Arkansas. In Arkansas, the state social services agency contracted to SCAN, Inc., a private organization, to provide services to all identified abuse cases in select counties. SCAN, in turn, demonstrated methods by which a resource poor state, like Arkansas, could expand its protective services capability by using lay therapists, supervised by SCAN staff, to provide services to those abuse cases.

The Family Care Center: Los Angeles, California. The concept behind the Family Care Center, a hospital-based program, was a demonstration of a residential therapeutic program for abused and neglected children with intensive day-time services for their parents.

The Child Development Center: Neah Bay, Washington. This Center, housed within the Tribal Council on the Makah Indian Reservation, demonstrated a strategy for developing a community-wide culturally-based preventive program, working with all those on the reservation with parenting or family-related problems.

The Family Resource Center: St. Louis, Missouri. A free-standing agency with hospital affiliations, the Family Resource Center implemented a family-oriented treatment model which included therapeutic and support services to parents and children under the same roof. The services to children, in particular, were carefully tailored to match the specific needs of different aged children.

Parent and Child Effective Relations Project (PACER): St. Petersburg, Florida. Housed within the Pinellas County Juvenile Welfare Board, PACER sought to develop community services for abuse and neglect using a community organization model. PACER acted as a catalyst in the development of needed community services, such as parent education classes, which others could then adopt.

The Panel for Family Living: Tacoma, Washington. The Panel, a volunteer-based private organization, demonstrated the ability of a broadly-based multidisciplinary, and largely volunteer program, to become the central provider of those training, education and coordinative activities needed in Pierce County.

The Union County Protective Services Demonstration Project: Union County, New Jersey. This project demonstrated methods to expand the resources available to protective services clients by contracting for a wide variety of purchased services from other public and, notably, private service agencies in the county.

III. Comparative Description of Projects

Project Goals. The range or scope of project goals were similar, embracing concerns for educating the general public and professionals about child abuse, helping to bring about a more coordinated community system, and the testing out of some particular set of treatment strategies for abusive and neglectful families, although the steps or means established for accomplishing these goals varied. For all projects, goals shifted during the first year as community needs and staff capabilities became more clearly defined; the shifts in goals resulted in more clear and realistic objectives. The amount of time required to clarify and stabilize goals may have been reduced with the assistance of the evaluators. In general, projects were more successful in accomplishing their community-oriented than their treatment-oriented goals.

Project Structures. The projects represented different ways in which child abuse and neglect service programs might be organized and the kinds of activities they might pursue. Six of the projects (Adams County, Arlington, Baton Rouge, Bayamon, Arkansas and Union County) were housed in protective service agencies; two in hospitals (Los Angeles and St. Louis); two in private agencies (St. Petersburg and Tacoma); and one in a tribal council (Neah Bay). Two of the projects served as the community-wide coordinating body for child abuse and neglect (Tacoma and St. Petersburg). While none of the projects focused on primary preventive services, all performed certain educational and coordinative activities that contribute to primary prevention. Two projects (Neah Bay and St. Petersburg) pursued secondary preventive services; the remainder focused on direct treatment services. Of those performing direct treatment, four (Adams County, Arlington, Los Angeles and St. Louis) provided services to both parents and children (of those, only three, all but Arlington, provided therapeutic services to children) and the remainder served only parents. Four of the projects used primarily professional workers (Arlington, Baton Rouge, Bayamon and Union County); two (Arkansas and Tacoma) represent primarily a lay or volunteer staff model; the remainder had mixed staff.

Implementation. The projects implemented the programs they intended to demonstrate with varying difficulty and in varying amounts of time (in as few as four months in Arlington and Baton Rouge, and over 18 months in Neah Bay and Los Angeles). Critical determinants of this appeared to include: relationship of proposal writers with project administration; relationship of host agency to other community agencies; complexity of the proposed demonstration; and the degree to which the organizational framework for the project was in place when funding occurred.

Organization and Management Styles. While the projects themselves, given their demonstration status, were all relatively small, informal and unstable compared to most existing state and local social service agencies, one sees diversity among them on many organizational and management characteristics. Notable differences between projects include budget, staff and caseload sizes, the diversity of activities pursued, and the numbers of different disciplines or agencies actively involved with the project, the degree of formalization of job design, job flexibility, rule observation, and the degree to which general organizational or specific job-related decisions were centralized.

Staffing Patterns and Staff Characteristics. It is difficult to describe and compare staffing patterns and staff characteristics given the relatively small staff sizes, the high turnover rates and the constant flux in number and types of staff positions and program participants. Core staff sizes ranged from three to 25; the average number of individuals (including consultants and volunteers) participating in a project ranged from five to 134. The majority of staff members across all projects were female. Some projects had a high proportion of professionally trained staff or staff with several years of experience in the field; others had very few. All projects used volunteers in a wide range of treatment, educational and support capacities. While volunteers were important additions to the projects, they did not come "free" but cost a project in terms of management, supervision and consultation time. Six projects (Arlington, Bayamon, Baton Rouge, Neah Bay, Tacoma and Union County) experienced a turnover in directors. Projects that hired new directors from existing staff (all but Baton Rouge and Tacoma) appeared to have many fewer problems of continuity and "down time" than projects that hired new directors from the outside. Because of the multiple demands on projects like these, treatment projects (including all but Bayamon and Neah Bay) benefitted from sorting out the functions of directing a project from those of supervising the treatment activities into two separate staff positions (a project director and a direct services coordinator). Projects with active advisory boards (Arlington, Arkansas, St. Petersburg, Tacoma and Union County) had an easier time solving problems as they arose, or anticipating them in advance, than did projects without such boards.

Project Activites and Resources. While the amount of time spent on different project activities and the magnitude or volume of the activities varied across projects, projects did pursue many of the same things.

The demonstration projects as a group, staffed by approximately 450 people (including volunteers), spent $2.21 million annually, which was matched by over $330,000 a year in donated resources. With an average of 800 cases in treatment per month over 2200 new cases were opened by the projects each year. Countless others received minimal, supportive services from the projects. Direct treatment services focused on the abusive or neglectful parent, with individual counseling being the most widely offered service, supplemented by crisis intervention, multidisciplinary team review and lay therapy services. Fewer than 175 children received direct treatment services from the projects each year. However, over 50,000 professional and lay people annually received direct education or training in matters pertaining to child abuse and neglect.

On an average, 25% of the projects budgets were used for community-oriented activities, 65% for direct treatment services and 10% for research. The allocation of project resources to different activities was quite stable during the period when projects were operational.

The unit costs of direct treatment services varied considerably with lay and group services being about the least expensive (with an across project average of $7.25 per lay therapy counseling contact; $9.50 per person for a parent education class; $10.50 per person for a group therapy session). Individual counseling cost about twice as much as lay therapy counseling ($14.75 per contact). Multidisciplinary team reviews cost the projects an average $54.75 per review; however, when the volunteered time of consultants is ascribed a dollar value, the cost per review rises to $125.50. Comparisons across projects revealed that projects with larger service volumes provided group services at lower unit costs; unit costs of individual-client services were not a reflection of service volume.

Characteristics of Families Served. A study of the characteristics of the families served by the projects suggests that despite projects' specific intake of admissions criteria, which influenced to some extent the kinds of cases served, projects still ended up serving a variety of cases. Projects found that many cases referred were accepted for treatment because they could not get services elsewhere, rather than because the parents had committed the kinds of abuse or neglect the project wanted to serve. Projects also realized that all cases are complex, changing over time such that a potential case becomes an actual case or an abusive parent develops neglectful patterns. This suggests that while projects may have decided to focus on a particular kind of case, caseloads could not be exclusive, and service offerings had to be flexible enough to meet the range of needs clients had.

The projects did serve a heterogenous group of clients, who, as a group, differ from cases routinely handled by public protective services departments in that a somewhat greater proportion are physical abuse (as opposed to neglect) cases; and they tend to have somewhat larger families, higher educational levels and suffer from financial and health problems as well as social isolation. While household conflict is not a problem among this study population as it is with protective services cases in general, the study cases are more likely to have been abused as children.

The most frequently offered service to clients was that of one to one counseling (including individual counseling and individual therapy). This service was most often complemented with crisis intervention, multidisciplinary team reviews, lay therapy, couples and family counseling, child care, transportation and welfare assistance. All other services were offered to 15% or fewer of the clients. Clients, on average, received three different types of services, were in treatment six to seven months, and had contact with service providers about once a week. Approximately 24% of the clients received a service package which included lay services (lay therapy counseling and/or Parents Anonymous) along with other servies. Only 13% received a group treatment package (including group therapy or parent education classes as well as other services); and over half (57%) received a social work model package (individual treatment and other services but no lay or group services).

Service receipt varied somewhat depending upon the type of maltreatment; cases designated as serious (in terms of the severity of the assault on the child) were more likely to receive multidisciplinary team case review couples/family counseling and crisis intervention. Some client characteristics appear to have been relevant in decisions to provide clients with certain mixes or models of service.

Approximately 30% of the cases in the study population were reported to have severly reabused or neglected their children while they were in treatment. By the end of treatment, 42% of the clients who at intake appeared to be likely repeaters were reported to have reduced propensity for future abuse or neglect. A somewhat smaller percent (36%) were said to have improved somewhat in aspects of daily functioning indicated to be a problem at intake.

Handling of Cases. More than one-half of the cases were contacted within three days of the initial report. Before coming to a decision on the plan of treatment for a client, usually at least one more meeting with the client in addition to the first contact was made; treatment services then would typically begin within two weeks of first contact with the client. Despite the interest and attention in the field to multidisciplinary review of cases, the typical case in the sample was not reviewed by a multidisciplinary review team at any time in the process. Use of outside consultants on the management of the case also was not the norm. On the other hand, whereas case conferences or staffings usually were not used on the case at intake or termination, there was a likelihood that such a conference was held sometime during the treatment phase of the case. The manager of the case was usually the person who also carried out the intake, and further, the typical case had only one case manager. Other than the primary case manager there was likely to be at least one other person in the project working with the client, and, at the same time, the client usually also received services from an outside agency. Evidence of communication and coordination with the source of the report and with outside treatment providers (if the client was receiving such services) was also the norm, but active client participation in treatment planning and reassessment was not the usual practice. On average, throughout the history of the case, the case manager would meet with the client about once or twice a month. After a case was terminated, usually a follow-up contact was made either with the client or with another service provider still working with the client. Many of these practices can serve as minimal case handling standards for others in the field.

Community Contexts and Constraints. The communities in which the projects were located varied by size and key demographic characteristics; these community characteristics did not seem to affect the implementation or short term operation of the projects as much as the nature of the local child abuse and neglect delivery system.

Attempts to better coordinate local child abuse and neglect systems took to form of organizing community-wide multi-agency coordinating groups and developing formal coordinative agreements with various agencies around the handling of specific case-management functions. Although there was no relationship between the project's sponsorship (e.g., public agency or independent) and their success in developing coordinating bodies, there was a relationship between sponsorship and a given project's ability to stimulate formal coordinating agreements between agencies on a system-wide basis. Thus, those projects that were protective service agency-affiliated developed more coordinative agreements between themselves and other agencies than independent projects.

The development of multi-disciplinary teams, either community-wide or agency-specific (project or hospital teams) was the primary method of securing interdisciplinary input for case review and management, although several projects also hired staff or consultants of various disciplines to extend the primary social work orientation of most community systems.

Centralized reporting systems and 24-hour coverage for the receipt of reports appear to have been solved satisfactorily in each of the demonstration communities except one. State legislation was clearly the major input to development of a centralized reporting system, and most often to the development of 24-hour coverage as well.

Each of the demonstration projects resulted in increased amounts and types of services available in their communities for dealing with child abuse and neglect cases, but the projects were generally unable to effect the provision of additional services by other community agencies. Many of the projects added relatively innovative services such as self-help programs, counseling hotlines, or educational services; since these services were generally available to only project clients, however, unless the projects were affiliated with the local protective services agency, the services were provided to only a small proportion of the community's cases. Preventive services were generally inadequate in the communites and only a few projects addressed these problems in any way. There was little proliferation of services for abused and neglected children. The utilization of community resources besides the demonstration projects and protective service agencies was generally poor. And, except for communities where the demonstration projects were housed in, or affiliated with, the local protective service agency, little change in the quality of case management, system-wide, was observed.

All of the projects provided extensive education and training to both professional and community residents. This education and training, although mostly focused on professionals, reached a wide audience; between 3,000 and 28,000 people in each community were educated during the course of the demonstration.

In summary, although the projects did have success in correcting many of the deficiencies in the community systems, especially problems of coordination, expansion of services under the projects' auspices, and professional education, several problems remain in the project communities at the end of the demonstration period. Coordination among both public and private agencies is inadequate; interdisciplinary input, while provided for in some cases, is not afforded the majority of the communities' cases; existing community resources have not been fully utilized in the provision of services; child neglect and high risk cases are provided minimal services; preventive services and therapeutic services for children are inadequate; and the case management function, particularly with respect to adherence to appropriate termination procedures and the provision of follow-up, is generally less than optimally carried out.

IV. Program Management and the Work Environment: The Causes of Worker Burnout

In order to gain insights into those organizational, management and personnel factors that contribute toward a positive work environment and thus reduce the likelihood of worker burnout (workers becoming separated or withdrawn from the original meaning and purpose of their work, estranged from their clients, their co-workers, the agency they work for such that they cannot and do not perform well on the job), each of the eleven projects' management processes and the attitudes of all workers at the projects were studied in detail. Data were collected from 162 workers. After identifying worker characteristics, management descriptors and organizational structure descriptors at each of the projects, these sets of factors were studied independently in terms of their relationship with the degree to which workers were burnt out. The most salient worker, management and organizational variables were then considered in combination to determine which had the stronger effects on burnout.

With structured, supportive program leadership standing out as the most influential management factor with respect to worker burnout, all of the following variables were found to have substantial or important effects: supportiveness; strength of program leadership; amount and clarity of communication; whether or not a worker had supervisory responsibility; degree of innovation allowed; age of worker; caseload size; the experience and sex of workers; and the degree to which rule observation was formalized.

It appears that burnout is not merely a function of a workers' own personal characteristics but also of the work environment. In order to avoid or diminish burnout among workers, and thus to enhance the longevity of worker and project performance, it would seem that a program needs to have quality leadership, clear communication, shared supervisory responsibility or supportive supervision, and smaller caseload sizes. A program should permit innovation as well as lack of adherence to certain formalized rules when it is in the best interest of clients. And programs should work carefully with younger, less experienced workers to help them avoid burnout.

V. The Essential Elements of a Quality Case Management Process

In order to determine the feasibility of measuring the quality with which cases were handled and to begin to identify the essential elements of quality case management, a representative sample of case managers' cases at nine of the demonstration projects were studied with respect to the case handling practices used, characteristics of the case manager, characteristics of the case and overall expert ratings of quality. Data on over 350 cases were analyzed with the following results:

Feasibility of Measuring Quality. It was found that reviewers can reliably collect factual information about case handling and that while acknowledged experts in the field generally rate quality in the same way as persons knowledgeable about child abuse but not "clinical experts," judgments about quality cannot be finely distinguished. At this point in the development of the field, judgments can only reliably be made between "good practice" and "less good practice."

Factors Associated with High Quality Intakes. The factors most highly associated with expert-judged quality intakes include: use of a multidisciplinary review team; minimal time (within one day, preferably) between the report and first client contact, use of outside consultation, and use of the same case manager for conducting the intake and managing ongoing treatment. The more education and experience the case manager has, the more likely that the intake will be of higher quality. Responsiveness of clients is also a factor in quality intakes.

Factors Associated with High Overall Quality Case Management. The factors most highly associated with expert-judged overall quality are: minimal time between the report and first client contact; use of outside consultants; frequent contact (ideally once a week) with client during the history of the case; a longer time in process (over six months). Clients perceived as responsive to treatment are more likely to receive quality case management. Factors with less significant but substantively interesting effects on quality include: contacting the reporting source for background information on the case; using multidisciplinary review teams and following up on clients after termination.

The Relationship between Elements of Case Management and Clinician-Reported Client Outcome. Of all the case management processes studied, the two with a direct relationship to clinician-reported client outcome are: smaller caseload size (under 20) and longer time in process (over six months). While quality case management greatly facilitates service delivery, and thus presumably client outcome, quality case management per se in this study was not shown to have a direct relationship with outcome.

VI. Treating Abusive and Neglectful Parents

In order to assess the relative effects of alternative service strategies for different types of abusers and neglectors, data on 1724 parents who received treatment from the projects were studied both by project and for the whole demonstration. The finding include:

Reincidence While in Treatment. Most client characteristics are not highly associated with reincidence. They type of abuse or neglect that brought the case into treatment in the first place and the seriousness of that maltreatment, however, are useful predictors in whether or not there will be reincidence. The services a client receives may be a function of whether or not reincidence in treatment has occured or may help explain why there is or is not reincidence. Keeping this in mind, specialized counseling is the service most highly associated with severe reincidence; receipt of parent education classes is least associated with this outcome. Seriousness of the assault that brought a case into treatment has a much stronger relationship with reincidence than these or any other services, or service models.

Improvement in Select Areas of Daily Functioning. Clients who both physically abuse and neglect their children, emotional maltreaters and clients with severe household situations (including a history of abuse and neglect) are less likely to improve on the functioning indicators used in this study. Other client descriptors have either very small or no relationship to whether or not such improvement is reported. Clients who are in treatment for at least six months, and clients who received lay services (lay therapy counseling or Parents Anonymous) are the clients most likely to show improved functioning (in those areas cited as a problem at intake) by the end of treatment. While no one discrete service stands out as having a strong effect on this outcome when others are controlled for, the lay service model (receipt of lay therapy and/or Parents Anonymous after professional intake does have the strongest effect of the service models studied. The lay model also has the strongest effect on improvement in each of the select areas of functioning, followed by the group model (receipt of group therapy or parent education classes along with other services).

Reduced Propensity for Future Abuse or Neglect. While potential and physical abusers are reported to be somewhat more likely to have reduced propensity for future abuse and neglect than other types of maltreators, there do not appear to be any client descriptors that have a strong effect on this outcome. Clients assigned to lay services (Parents Anonymous and lay therapy) were reported to be those more likely to have improved by the end of treatment than clients receiving other services. Length of time in treatment appeared to have a strong effect on outcome; frequency of contact had a small but substantively interesting effect. The only client descriptors which helped to explain outcome when considered along with service provision were the absence of substance abuse as a problem and the absense of severe reincidence during treatment. When cases are studied by type of maltreatment, the lay model continues to appear as having a stronger effect than other services for all groups except physical abusers, for whom the group service model has a slightly stronger effect.

Outcome Findings and Implications. Given that about 30% of the clients served were reported with severe reincidence while in treatment, the initial intervention strategies of the projects are called into question, suggesting that projects were not successfully protecting families' children. Also only 42% of the projects' clients who were reported at the beginning of treatment to be likely repeators, many of whom did severely reabuse or neglect during treatment, were found to have reduced propensity for future abuse or neglect by the end of treatment. Comparisons with findings from other studies to determine the validity of this finding are not possible, given the paucity of other evaluation studies in the field and lack of comparability between those completed to date. These findings do suggest that (a) more effective, early intervention strategies for protecting the child must be identified, and (b) irrespective of the success of early intervention, most child abuse and neglect programs currently can probably not expect to have much more than a 40-50% success rate. It should be kept in mind that lay treatment services followed professional intake and lay therapists had training and supervision on an ongoing basis.

Treatment Outcome Findings and Cost Implications. It was learned in this study that relative to any other discrete services or combinations of services, the receipt of lay services -- lay therapy counseling and Parents Anonymous -- combined with other services is more likely to result in positive treatment outcome. Group services (group therapy, parent education classes) as supplements to a treatment package also have a notable effect particularly for the physical abuser. Providing treatment for more than six months also appears to contribute toward treatment success.

These services which proved more effective also tend to be those which are the least expensive. For example, providing lay therapy counseling to a client for one year is estimated to cost $377 as contrasted with $546 for group therapy and $767 for individual counseling. The annual cost for a client in a program emphasizing lay services is $1380 as contrasted with $1691 in a program emphasizing individual counseling. The cost per successful outcome in a lay-oriented program is $2590 per client year, the most cost-effective treatment program. Comparable costs per successful outcome in a program emphasizing non-lay individual counseling is $4662 and $4081 in a program emphasizing group services. The group model is more effective and less costly than the social work model. In addition, it is more cost-effective to keep a client in treatment over six months.

VII. Treating Abused and Neglected Children

In order to determine the characteristics and types of developmental, emotional and psycho-social problems which abused and neglected children have, and the effects of providing therapeutic interventions to ameliorate these problems, the children receiving direct services at three demonstration projects were followed from intake through termination. Data on 70 children, and 44 of their parents, were analyzed with the following results.

Problems of Abused and Neglected Children. Children who entered the projects for treatment displayed a wide variety of problems; there was not one area in which all children were deficient, nor were there specific types of problems or behaviors which clustered together. The greatest number of children had problems in the following area: (1) physical problems -- hyperactivity, erratic eating patterns, excessive crying behavior, and the presence of tics and twitches; (2) socialization problems -- poor interaction with peers and adults, over-reation to frustration and very short attention spans; (3) family interaction problems -- inappropriate perception of child's needs and response to these needs, child's differences from parent's expectations and child's provocative behavior; (4) cognitive/language/motor skill problems -- the majority of the children tested below one standard deviation under the mean on several standardized tests, placing them in the clinical "dull normal" range.

Progress While in Treatment. Many children made some progress on their problems while in treatment; the problems of 50% of the children were reported to be completely ameliorated in areas of malnutrition, delayed height and head circumference, eating patterns, ability to gain and receive affection, hypermonitoring, and ability to protect themselves, apathetic behavior, general interaction with peers and the parent's use of harsh discipline on the child. At the time of termination, most children had significantly higher scores on the standardized tests administered (meaning cognitive, language and motor skill) although they were still at the low end of the "normal" range. Many children's problems, however, remained unchanged, and a small proportion were reported to have regressed during treatment.

Factors Associated with Progress in Treatment. The seriousness of the case at intake, the presence of abuse or neglect reincidence while in treatment, and the length of treatment were not shown to be good predictors of how a child will progress in treatment. Children appeared to have scattered success in overciming their problems in much the same way that they exhibited a wide variety of problems, and intensity of problems, at the time they entered treatment.

VIII. Conclusions and Recommendations

In conclusion, it would appear that child abuse and neglect services are maximized:

- if they are closely linked with or housed within public, protective services agencies;
- if the program participates cooperatively with law enforcement, local schools, hospitals and private social service agencies in the community in the identification and treatment of abuse and neglect as well as the education and training of professionals and the general public;
- if the program has strong, supportive leadership, a variety of disciplines on the staff, decentralized decision making, clearly specified rules but allowance for flexibility of the rules as clients' needs dictate;
- if the program stresses certain aspects of case management including prompt, planful handling of cases, frequent contact with cases, small caseload sizes, coordination with other service providers and use of multidisciplinary review teams and consultant input for the more complex or serious cases;
- if the program utilizes more highly trained, experienced workers as case managers, but stresses the use of lay services (lay therapy) and self-help services (Parents Anonymous) as part of its treatment offerings, as well as 24-hour availability;
- if careful supervision is available to lay workers, particularly during the first few months they are working with a case.
- if therapeutic treatment services are provided to the abused or neglected child

Even the more successful child abuse and neglect service programs should not expect to be completely effective with their clients. To successfully treat half of one's clients, so that they need not become protective service cases in the future, appears to be a norm for the field.

IX. Annotated Bibliography of Final Reports from the Evaluation

(1) A Comparative Description of the Eleven Joint OCD/SRS Child Abuse and Neglect Demonstration Projects: This report is a descriptive analysis of eleven demonstration child abuse and neglect services projects, spread across the country and in Puerto Rico. It includes discussion of the projects' goals, the major activities they pursued, how resources were used, their organizational base and management structure, staffing patterns, services provided to clients and to the rest of the community, the types of clients served and how cases were managed. The report stresses the similarities and differences across projects and the kinds of problems they encountered in implementing their programs.

(2) Historical Case Studies: Eleven Child Abuse and Neglect Projects, 1974-1977: A detailed description of each of eleven demonstration child abuse and neglect service projects is provided in this report. Contents include discussion of: the community context; the project's history; organization and staffing patterns; project components; implementation and operation problems; project goals and how well they were accomplished during three years of federal funding; project management and worker satisfaction and burnout; clients served and the impact of services on those clients; impact of the project on the local community; resource allocation and service volume and costs; and plans for continuation after federal funding.

(3) Cost Report: This report provides an analysis of the utilization of resources (both dollars and personnel) in eleven demonstration child abuse and neglect service projects. The overall demonstration effort is analyzed in terms of what it bought. The allocation of individual project and overall program resources to different service and treatment activities are presented. The unit costs of different treatment services and the consequent costs of alternative service program models are discussed. The reports includes analysis of service volume economies and the factors associated with cost efficiency in child abuse programs. Also included is a detailed discussion of the cost analysis methodology.

(4) Community Systems Impact Report: This report presents an analysis framework for studying the impacts of eleven demonstration child abuse and neglect projects on their local child abuse and neglect service systems. In the context of this framework, the impact of individual projects on their community systems and a comparative analysis of impact are discussed. Central to the analysis are factors associated with improvement in the following areas: community coordination mechanisms; interdisciplinary input at all treatment stages; a centralized and responsive reporting system; availability of a comprehensive set of services; the quality of case management through out the system and the level of community education and public awareness.

(5) Adult Client Impact Report: In addition to describing the kinds of clients served, the kinds of services provided and the impacts of services on clients at eleven demonstration child abuse/neglect projects this report presents an analysis of the effectiveness of alternative service strategies for abusive and neglectful parents. Several different kinds of impact measures are used, including reincidence while in treatment and reduced propensity for future maltreatment by the time services are terminated. The analyses include: the relationship between different client characteristics and impact; the relationship between different mixes of services received and impact; and the combined relationships between client characteristics, services received and impact. Analyses are presented for individual projects and for the whole demonstration program. The report includes a detailed discussion of the methodology.

(6) Child Impact Report: The kinds of children served and the progress made by these children during treatment at three of eleven demonstration child abuse and neglect service projects are discussed. Information on the problems abused and neglected children had at the time they entered treatment and the progress made on those problems during the treatment process forms the basis for the analysis. Categories of problem areas include: physical development; socialization skills; and interaction with peers, adults and family members. The report includes a discussion of the difficulties in studying abused and neglected children with the use of standardized tests and the methodology used in this study.

(7) Quality of the Case Management Process Report: This report describes the development of a methodology for determining the quality of the case management process in child abuse and neglect service programs as well as the application of this method to nine of eleven demonstration child abuse and neglect service projects. Included in the report are: a detailed discussion of the methodology; an assessment of the feasibility of collecting reliable data on this subject in the child abuse field; a description of the case management process at the demonstration projects; and an analysis of the factors associated with high quality case management. Suggested minimal standards of case management for the field are presented as well. The method used is adapted from the medical care quality assessment field.

(8) Project Management and Worker Burnout Report: This report describes the organization and management of eleven demonstration child abuse and neglect projects and analyzes the relationships between salient organization, management and worker characteristic variables with the presence and degree of worker burnout in these projects. Worker burnout is defined and a list of indicators of burnout is presented. In addition to determining which of a number of factors appear to be most highly associated with burnout, the report presents a series of recommendations to local child abuse and neglect projects on ways to avoid worker burnout. The findings are equally applicable to other kinds of social service agencies. A detailed discussion of the methodology used is also provided.

(9) Methodology for Evaluating Child Abuse and Neglect Service Programs: This report presents a detailed discussion of the methodologies used in evaluating eleven child abuse and neglect demonstration service projects. These methods, which should be adaptable to non-demonstration child abuse and neglect projects as well, include: measuring project goal attainment; monitoring project resource allocation and service costs; determining the quality of the project's case management process; analyzing project organization and management and their relationships with worker job satisfaction and burnout; assessing the effectiveness of alternative service strategies for abusive and neglectful parents; monitoring the progress of abused and neglected children while in treatment; and assessing the impact of a project on its local child abuse and neglect system. In addition to describing the evaluation process, problems encountered and the methods used, the report contains all relevant data collection instruments and instruction manuals.

(10) Guide for Planning and Implementing Child Abuse and Neglect Programs: This guide describes the process of planning and implementing child abuse and neglect service programs. It begins with a description of the planning process and the essential elements of a well-functioning community-wide child abuse and neglect service system. The steps involved in conducting a community needs assessment are presented as well as the kinds of problems typically encountered in setting up a new program. Methods for identifying project goals and examples of realistic goals are presented. Alternative program designs are described as are alternative treatment strategies a program may wish to provide. Methods for monitoring case management practices, client progress and project resource allocation are talked about and sample case record and program record instruments are supplied. The guide concludes with a discussion of ways to ensure cooperative working relationships with other community agencies and among program staff and ways to avoid worker burnout, as well as summary comments about how to enhance the likelihood of establishing an effective program.

(11) Child Abuse and Neglect Treatment Programs: Final Report and Summary of Findings: This report summarizes the findings from a three-year evaluation of eleven child abuse and neglect demonstration service projects. Contents include: a description of the eleven demonstration projects in terms of their goals, service activities, organization and management styles, staffing patterns, resource allocations and service costs, types of clients served, methods of case management used and community activities; the factors associated with worker burnout; the essential elements of a quality case management process; the factors associated with program efficiency; the relative effectiveness of alternative service strategies for abusive and neglectful parents and the cost-effectiveness of different services; the effects of treatment for abused and neglected children. Recommendations regarding the elements of successful child abuse and neglect projects are also presented.